

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

12227

12213

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Towson</b> c. LENGTH OF STAY IN <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>409 Range Road</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Towson</b> d. STREET ADDRESS <b>409 Range Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) <b>EVELYN HEWETT ACKROYD</b> First Middle Last				<b>4. DATE OF DEATH</b> <b>November 27, 1961</b> Month Day Year					
<b>5. SEX</b> <b>Female</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>October 20, 1911</b>		<b>9. AGE</b> (In years last birthday) <b>50</b> yrs. IF UNDER 1 YEAR: Months Days Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Own Home</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Mass.</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>William Walker Hewett</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Hulda M. Bleakney</b>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b> (If yes give year or dates of service)				<b>16. SOCIAL SECURITY NO.</b> <b>None</b>		<b>17. INFORMANT</b> <b>Whiteley I. Ackroyd, 409 Range Rd., Towson, Md.</b>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> (b) <b>Bronchogenic carcinoma of right upper lobe with diffuse Metastasis</b> (c) <b>Myocardial infarction and pericarditis with effusion due to metastatic carcinoma</b> DUE TO <b>162.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								INTERVAL BETWEEN ONSET AND DEATH <b>15 months</b> <b>4 months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)			
<b>21. I certify</b> that (I) (this hospital) attended the deceased from <b>Sept 15, 1960</b> to <b>Nov 27, 1961</b> , that (I) (we) last saw the deceased alive on <b>Nov 21, 1961</b> , and that death occurred at <b>545A</b> M, from the causes and on the date stated above.									
<b>22a. SIGNATURE</b> <b>S. J. Liu</b> M.D.				<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/> <b>22b. DATE SIGNED</b> <b>Nov. 28 '1961</b>					
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>S. J. Liu</b>				<b>22d. ADDRESS</b> <b>5301 Harford Road, Baltimore, Md.</b>					
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>Nov. 29, 1961</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Dulaney Valley Memorial</b>		<b>23d. LOCATION</b> (City, town or county) (State) <b>Cockeysville, Maryland</b>			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>John Burns' Sons, Towson, Maryland</b>				<b>25a. REC'D BY REGISTRAR</b> <b>DATE DEC 1 '61</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Frank</b>			

MEDICAL CERTIFICATION

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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Baltimore

Towson

409 Ridge Road

EVAN HUNTER AGENCY

x

White Plains

Honolulu

William Walter Hewitt

10 Home

Maryland

Towson

409 Ridge Road

October 20, 1961

Two Home

Maryland

John F. Blaney

10 Home, 409 Ridge Road, Towson, Md.

USA

November 27, 1961

x

United States, 20, 1961

John F. Blaney, Towson, Maryland

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12228

## CERTIFICATE OF DEATH

12214

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> <span style="float: right;"><b>MARYLAND</b></span> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> c. LENGTH OF STAY IN 1b <u>6yrlmthl8dys</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>SPRING GROVE STATE HOSPITAL</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> <span style="float: right;">b. COUNTY <u>Pr. Geo.</u></span> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bradbury Heights, Maryland</u> <span style="float: right;"><u>1625-2</u></span> d. STREET ADDRESS <u>5207 Alton Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
<b>3. NAME OF DECEASED</b> (Type or print) <u>Orville Edwin Albrecht</u>		<b>4. DATE OF DEATH</b> Month <u>November</u> Day <u>24</u> Year <u>19 61</u>		<b>5. SEX</b> <u>male</u>		<b>6. COLOR OR RACE</b> <u>white</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>Oct. 2, 1900</u>		<b>9. AGE</b> (In years last birthday) <u>61</u> yrs. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		<b>10e. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>carpenter</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>  </u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>North Dakota</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U. S. A.</u>	
<b>13. FATHER'S NAME</b> <u>Edward Albrecht</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>Margaret T. Fried</u>															
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>un.</u>						<b>16. SOCIAL SECURITY NO.</b> <u>579-24-8227</u>						<b>17. INFORMANT</b> Address <u>Records: SPRING GROVE STATE HOSPITAL</u>									
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>  </u> (a), stating the underlying cause last. DUE TO (c) <u>  </u>														INTERVAL BETWEEN ONSET AND DEATH <u>  </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Huntington's Chorea</u>																					
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>																					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>  </u>				<b>20f. (City or town)</b> (County) (State) <u>  </u>									
<b>21. I certify</b> that <del>he</del> (this hospital) attended the deceased from <u>Oct. 4</u> <u>1955</u> , to <u>Nov. 24</u> <u>1961</u> , that (I) (we) last saw the deceased alive on <u>Nov. 24</u> <u>1961</u> , and that death occurred at <u>1:45</u> P.M. from the causes and on the date stated above.																					
<b>22a. SIGNATURE</b> <u>Stella Wachsler</u> M.D.								<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/> <u>11-24-61</u>				<b>22b. DATE SIGNED</b>									
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>STELLA Wachsler, M. D.</u>								<b>22d. ADDRESS</b> <u>SPRING GROVE STATE HOSPITAL</u> <u>Catonsville 28, Maryland</u>													
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>BURIAL</u>				<b>23b. DATE THEREOF</b> <u>11-27-61</u>				<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Cedar Hill</u>				<b>23d. LOCATION</b> (City, town or county) (State) <u>Smithland, Ind.</u>									
<b>24 FUNERAL DIRECTOR'S SIGNATURE</b> <u>JAMES T. RYAN, INC.</u> ADDRESS <u>317 PA. AVE. S.E.</u>								<b>25a. REC'D BY REGISTRAR</b> <u>NOV 27 '61</u>				<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kraus</u>									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b> c. LENGTH OF STAY IN lb <b>11 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Veterans Administration Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>1525 Arbutus Ave</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>HENRY J ALLEN</b>		4. DATE OF DEATH Month <b>November</b> Day <b>19</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 5, 1899</b>
9. AGE (In years last birthday) <b>62 yrs.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Millwright (Unemployed) Repair</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Buffalo, New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>Joseph Allen</b>		14. MOTHER'S MAIDEN NAME <b>Pauline Brown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>216-07-9380</b>	
17. INFORMANT <b>Clinical Rec. VAH Balto 18, Md Ft Howard Div</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>HEART FAILURE</b> <b>465X</b> DUE TO <b>PULMONARY EMBOLI</b> Conditions, if any, which gave rise to immediate cause (b) (c) <b>465X</b> DUE TO <b>PULMONARY EMBOLI</b> (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Bronchial Asthma</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <b>e.m.</b> Month, Day, Year <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <b>10</b> (this hospital) attended the deceased from <b>November 8, 1961</b> to <b>November 19, 1961</b> , that <b>10</b> (we) last saw the deceased alive on <b>November 19, 1961</b> and that death occurred at <b>10:15 PM</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Rowland H Robertson, Jr.</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>ROWLAND H ROBERTSON, JR.</b>		22d. ADDRESS <b>VAH BALTO 18, MD., FT HOWARD DIVISION</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/24/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Meadow Ridge Memorial Park</b>		23d. LOCATION (City, town or county) (State) <b>Washington Blvd &amp; Dorsey Rd Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Stansbury Funeral Home 6411 Windsor Mill Rd Balto Md</b>		25a. REC'D BY REGISTRAR <b>NOV 22 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

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Stansbury Personal Home 2111 Windsor Hill Rd

WAS BIRTH 1918 IN ... TO ROBERT DIVISION

November 1918 ...

Stansbury Personal

ROBERT DIVISION  
PERSONAL RECORD

... 1918 ...

Joseph ...

... (unofficial) ...

... Nov 1918 ...

... white ...

... January 1919 ...

HEART

ALLEN

November 1918

Veterans Administration Hospital

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... all days ...

... 1918 ...

... 1918 ...

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FOR STATE  
HEALTH DEPT.

TO DIRECTOR: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 7/59

12230

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12216

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baynesville</u>		c. LENGTH OF STAY IN 1b <u>X</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baynesville</u>		d. STREET ADDRESS <u>1431 E. Joppa Rd.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>1431 E. Joppa Rd.</u>				d. STREET ADDRESS <u>1431 E. Joppa Rd.</u>		a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Claude Eugene Allender</u>		4. DATE OF DEATH Month <u>11</u> Day <u>10</u> Year <u>19 61</u>		5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-16-1900</u>		9. AGE (In years last birthday) <u>61</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>1</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Fireman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Balto. City</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George W. Allender</u>		14. MOTHER'S MAIDEN NAME <u>Emma C. Roberts</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Mrs Anna E. Allender</u>		Address <u>same</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Diabetes Mellitus</u> DUE TO (c) <u>Arteriosclerotic Cardiovascular</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>6 yrs</u> <u>1 yr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Charles F. O'Donnell</u>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>11/11/61</u>	
EXAMINER'S NAME (Type) <u>Charles F. O'Donnell</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>11-13-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Moreland Mem. Park</u>		22d. LOCATION (City, town, or country) (State) <u>Baltimore Md.</u>	
23. FUNERAL DIRECTOR <u>Leonard J. Ruck 5305 Harford Rd.</u>				24a. REC'D BY REGISTRAR <u>NOV 14 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Be 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12231

## CERTIFICATE OF DEATH

12217

Item 13 Film G300 11/10/61 mh

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>1yr5mth18dys</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Whiteford, Maryland</b>	
3. NAME OF DECEASED (Type or print) First <b>Lena</b> Middle <b>Arndt</b> Last <b>Arndt</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>2</b> Year <b>1961</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 7, 1892</b>
9. AGE (In years last birthday) <b>69</b> yrs.		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Ida Leeper</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>unknown</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Possibly generalized infection (Septicemia)</b> 715X DUE TO <b>mal nutrition, poor organic defenses</b> Conditions, if any, which gave rise to immediate cause (b) <b>spread infection from decubitus scars and boils</b> (c) <b>Generalized arteriosclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Generalized arteriosclerosis</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>March 10, 1960</b> to <b>Nov 2nd, 1961</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Nov 2nd, 1961</b> , and that death occurred at <b>5:20 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Jose R. Arizaga, M.D.</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>JOSE R. ARIZAGA, M.D.</b>		22d. ADDRESS <b>SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland</b>	
23a. BURIAL OR CREMATION, REMOVAL (Specify) <b>Nov. 5, 1961</b>		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY <b>Emory Cem</b>		23d. LOCATION (City, town or county) (State) <b>Harford Co, Md,</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>H S Bailey</b>		24b. ADDRESS <b>Harlington Md</b>	
25a. REC'D BY REGISTRAR <b>NOV 7 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kuma</b>	

1881

(M)

(J)

Wm. H. Barry  
Nov 3 1881  
H. H. Barry



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12232

## CERTIFICATE OF DEATH

12218

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Balto</u> <span style="float: right;">b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Upperco Rural</u></span> c. LENGTH OF STAY IN 1b <u>1 yr</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) _____				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> <span style="float: right;">b. COUNTY <u>Balto</u></span> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Upperco Rural</u> d. STREET ADDRESS <u>1</u> e. IS RESIDENCE ON A FARM? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO									
<b>3. NAME OF DECEASED</b> (Type or print) <u>WILLIAM - H - ARNOLD</u> First Middle Last				<b>4. DATE OF DEATH</b> <u>Nov 18</u> 19 <u>61</u> Month Day Year									
<b>5. SEX</b> <u>M</u>		<b>6. COLOR OR RACE</b> <u>W</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>Sept 1 - 1916</u>		<b>9. AGE</b> (In years last birthday) <u>45</u> yrs.		<b>IF UNDER 1 YEAR</b> Months _____ Days _____		<b>IF UNDER 24 HRS.</b> Hours _____ Min. _____	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Merchant</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Genl store</u>				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Maryland</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>Herschel Arnold</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>Emma Barnes</u>							
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>yes</u>				<b>16. SOCIAL SECURITY NO.</b> <u>WW-2-216-03-2343</u>				<b>17. INFORMANT</b> <u>Mrs Wm A Arnold, Upperco Md</u> Address _____					
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cornary Thrombosis</u> <u>420.1</u> DUE TO <u>Arterio. Sclerosis Coronary Disease</u> Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause last, _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____												<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>5 min</u> <u>1 year</u>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) _____													
<b>20c. TIME OF INJURY</b> Hour _____ e.m. _____ p.m. _____ Month, Day, Year _____ 19 _____				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) _____		<b>20f. (City or town)</b> _____		<b>(County)</b> _____		<b>(State)</b> _____	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>June 11-17</u> 19 <u>60</u> , <b>to</b> <u>11-18</u> 19 <u>61</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>11-17</u> 19 <u>61</u> , <b>and that death occurred at</b> <u>3 p.m.</u> <b>from the causes and on the date stated above.</b>													
<b>22a. SIGNATURE</b> <u>M. C. Porterfield</u> M.D.						<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <u>11-20-61</u>					
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>M. C. Porterfield</u>						<b>22d. ADDRESS</b> <u>Hampstead Md</u>							
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>				<b>23b. DATE THEREOF</b> <u>Nov 21-61</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Trenton</u>				<b>23d. LOCATION (City, town or county)</b> <u>Balto Co Md</u>		<b>(State)</b> _____	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>TIPTON - ELINE - Hampstead Md</u>						<b>25a. REC'D BY REGISTRAR</b> <u>NOV 21 '61</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kline</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 22b, Film G301 11/20/61 iwk

CERTIFICATE OF DEATH

Reg. Dist. No. 12219

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Towson</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Villa Maria - Notch Cliff</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Sister M. Firmina</b> Middle <b>(Auth)</b> Last		4. DATE OF DEATH Month <b>11</b> Day <b>9</b> Year <b>19 61</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4 - 25 - 1870</b>
9. AGE (In years last birthday) yrs. <b>91</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Teacher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>RELIGIOUS</b>	
11. BIRTHPLACE (State or foreign country) <b>New Jersey</b>		12. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
13. FATHER'S NAME <b>Joseph Auth</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Pfeifer</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Sr.M. Henrieta</b>		Address <b>Villa Maria Glenarm, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary edema</b> <b>450.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized Arteriosclerosis</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>2 da.</b> <b>10 yrs.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May</b> , 19 <b>47</b> , to <b>November</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>Nov. 9</b> , 19 <b>61</b> , and that death occurred at <b>7</b> p.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>Charles F. O'Donnell</b> M.D.			
PHYSICIAN'S NAME (Type) <b>Dr. Charles F. O'Donnell</b> <b>7501 York Road Towson 4, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>11-13-61</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>VILLA MARIA CEM.</b>		22d. LOCATION (City, town, or county) (State) <b>NOTCH CLIFF NR TOWSON, MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles S. Zeiler</b>		24. REC'D BY REGISTRAR DATE <b>NOV 13 '61</b>	
ADDRESS <b>9015 CONKLING ST. BALTO., 24, MD.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur E. Harris</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b> c. LENGTH OF STAY IN 1b <b>30 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Veterans Administration Hospital</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>-</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>3408 Forest Park Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>BENJAMIN BARTON BAKER</b>						4. DATE OF DEATH Month <b>November</b> Day <b>11</b> Year <b>1961</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>August 13, 1891</b>		9. AGE (In years last birthday) <b>70 yrs.</b>		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Attorney</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>self employed</b>				11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Tobias Baker</b>						14. MOTHER'S MAIDEN NAME <b>Sarah Ades</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>						16. SOCIAL SECURITY NO. <b>WWI</b>					
17. INFORMANT <b>Clinical Records, VAH, BALTIMORE, MD.</b>						18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHO PNEUMONIA DUE TO PROTEUS AND COLIFORM ORGANISMS</b> 491 X DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>491 X</b> (c) <b>491 X</b> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>ENCEPHALITIS LETHARGICA CHRONIC PROGRESSIVE WITH PARKINSONISM</b> <b>MANIFESTATIONS 2. DIABETES MELLITUS 3. OSTEOARTHRITIS</b>					
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Baltimore</b>		20g. (County) <b>BALTO.</b>		20h. (State) <b>MD.</b>	
21. I certify that <b>10</b> (this hospital) attended the deceased from <b>October 12, 1961</b> , to <b>November 11, 1961</b> , that <b>4</b> (we) last saw the deceased alive on <b>November 11, 1961</b> , and that death occurred at <b>5:15 AM</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>C. M. Snyder</b>						22b. DATE SIGNED <b>11/11/61</b>					
22c. PHYSICIAN'S NAME (Type) <b>C. M. SNYDER, M.D.</b>						22d. ADDRESS <b>VAH, BALTO. MD. - FT HOWARD DIVISION</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11-12-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Beth T. Feloh</b>		23d. LOCATION (City, town or county) <b>Balto</b>		23e. (State) <b>MD.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Jack Lewis, Inc., 2100 Eutaw Place, Balto. Md.</b>						25a. REC'D BY REGISTRAR <b>NOV 14 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kram</b>			

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15M 9/60

3230

PHOTO OF

1934

(M)

No date

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INVESTIGATION

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Jack Smith, who, since then, has



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12235

12221

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> <u>MARYLAND</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residencia before admission) a. STATE <u>Maryland</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>22yr6mth25dys</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SPRING GROVE STATE HOSPITAL</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>522 East Eager Street</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Hugh</u> Middle <u>P.</u> Last <u>Bannon</u>		<b>4. DATE OF DEATH</b> Month <u>November</u> Day <u>24</u> Year <u>19 61</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 9, 1895</u>
9. AGE (In years last birthday) <u>66</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>plumber - retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>	11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>Hugh Patrick Bannon</u>		14. MOTHER'S MAIDEN NAME <u>Catherine O'Neill</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>unknown</u>	17. INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>  </u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> a.m. p.m. <u>  </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	20f. (City or town) (County) (State) <u>  </u>
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>April 22, 1939</u> to <u>Nov. 24, 1961</u> , that (I) (we) last saw the deceased alive on <u>Nov. 24, 1961</u> , and that death occurred at <u>12:30 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Stella Wachslar</u>		22b. DATE SIGNED <u>11-24-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Stella Wachslar, M. D.</u>		22d. ADDRESS <u>SPRING GROVE STATE HOSPITAL</u> <u>Catonsville 28, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>11-27-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Ickow &amp; Sons</u>		25a. REC'D BY REGISTRAR <u>NOV 24 '61</u>	
ADDRESS <u>Baltimore 17, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12236

Item 21 Film G302 12/13/61 jwk

12222

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b> c. LENGTH OF STAY in lb <b>7 Days</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore 22, Maryland</b> d. STREET ADDRESS <b>7518 Carroll Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>(Served as NELSON NELSON)</b> First Middle Last <b>H. BARTELL BARTELL</b>		4. DATE OF DEATH Month Day Year <b>November 30 19 61</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 16, 1891</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Watchman - Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Oil Company</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Canton, Maryland</b>
13. FATHER'S NAME <b>Jacob Bartell</b>		14. MOTHER'S MAIDEN NAME <b>Mamie Clark</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>214-01-4388</b>	
17. INFORMANT <b>Clinical Records, VAH, Baltimore 18, Maryland</b> <b>Fort Howard Division</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ADENOCARCINOMA OF PANCREAS WITH METASTASES TO LIVER</b> <b>157X</b> <b>XXXXX AND LEFT INTERNAL CAPSULE OF BRAIN</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>BILATERAL LOBAR PNEUMONIA</b> <b>XXXXX</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b> <b>2 DAYS +</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from <b>11/23/61</b> to <b>11/30/61</b> , 19 <b>61</b> , that (1) (we) last saw the deceased alive on <b>December 20, 1961</b> , and that death occurred at <b>5:15 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Sebastian Russo</b>		22b. DATE SIGNED <b>12/1/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>SEBASTIAN RUSSO, M.D.</b>		22d. ADDRESS <b>VAH, BALTO. 18, MD., FT. HOWARD DIVISION</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Dec. 4/61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Garden of Hope Cemetery</b>	23d. LOCATION (City, town or county) (State) <b>Baltimore County, Maryland</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Philip Herwig &amp; Sons</b>		25a. REC'D BY REGISTRAR <b>DEC 4 '61</b>	
ADDRESS <b>2024 Orleans St. Balto. Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>	

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Port Howard

1 day

December 22, 1941

Veterans Administration Hospital

Port Howard

(Served in Korea)

(Served in Korea)

November 30

Miss

Only 15, 1941

Frederick - Nelson

Oil Company

Common, 1941

Jacob - Brown

Yes

1941-1942, Port Howard Division

INVESTIGATION OF FACTORS WITH REFERENCE TO LIVES

AND THE FACTORS OF DEATH

INVESTIGATION OF FACTORS WITH REFERENCE TO LIVES

1941

1941-1942

*Handwritten signature*

BRIGADIER GENERAL, M.D.

WAR, 1941-1942, T. ROBERTS DIVISION

BRIGADIER GENERAL, 1941-1942

1941-1942, 85. 1941-1942

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the attending physician and completed and signed by the funeral director. After this certificate has been signed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
12237													
CERTIFICATE OF DEATH													
Item 16 Film G302 12/6/61 iwk 12223													
1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)											
a. COUNTY		BALTIMORE					a. STATE					b. COUNTY	
		MARYLAND					MARYLAND					BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		WOODBROOK					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					WOODBROOK	
c. LENGTH OF STAY IN 1b		50 yrs.					d. STREET ADDRESS					7208 Bellona Ave.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		(died at his residence)					e. IS RESIDENCE ON A FARM?					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH											
		November 29 19 61											
5. SEX		6. COLOR OR RACE		7. MARRIED		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR			
MALE		WHITE		<input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		Nov-2-1890		71 yrs.		Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?							
LAWYER		LAW		Baltimore, Md		U.S.							
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME											
J. KEMP BARTLETT		MARY DIXON											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address							
yes		WW-1		216-14-5374		J. Kemp Bartlett 3rd--Cockeysville, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		443X DUE TO Hemorrhage, cerebral,										2-3 days	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) Hypertensive Cardiovascular Disease										Several years (10)	
(c)													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED?											
		YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
Hour a.m. p.m.		While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				Nov 22, 1929 to Nov 29, 1961		Nov 29, 1961		Nov 30 '61			
21. I certify that (I) (this hospital) attended the deceased from		22a. SIGNATURE											
saw the deceased alive on		John T. King											
22b. DATE SIGNED		Nov 29, 1961											
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS											
John T. King, M.D.		1210 Eutaw Place, Baltimore 17, Maryland.											
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county)		(State)					
burial		Dec-1-1961		Druid Ridge		Pikesville, Baltimore 8							
24. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Stewart & Mowen Co., 108-W-North-Av, Balto 1				DATE DEC 1 '61		Anthony S. Hantz							

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12238

## CERTIFICATE OF DEATH

12224

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Baltimore</b> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b> c. LENGTH OF STAY IN b1 <b>22 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Veterans Administration Hospital</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) e. STATE <b>Maryland</b> <span style="float: right;">b. COUNTY <b>Baltimore</b></span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore - 21</b> d. STREET ADDRESS <b>Lot 120 Cedar Beach</b> a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <b>HENRY</b>		First Middle Last <b>-- BAUER</b>		<b>4. DATE OF DEATH</b> Month Day Year <b>November 5 1961</b>			
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>June 15, 1906</b>		<b>9. AGE</b> (In years last birthday) <b>55 yrs.</b>		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Custodian</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Balto. Co. Schools</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Baltimore, Maryland</b>			
<b>13. FATHER'S NAME</b> <b>Charles Bauer</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Anna Margaret Fresterman</b>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>Yes</b>		<b>16. SOCIAL SECURITY NO.</b> <b>WM-11 212-10-1407</b>		<b>17. INFORMANT</b> Address <b>Clinical Records VAH, 3900 Loch Raven Blvd. Balto 18, Md-FORT HOWARD DIVISION</b>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>INFARCTION OF MYOCARDIUM</b> DUE TO <b>420.0</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
INTERVAL BETWEEN ONSET AND DEATH <b>3 weeks</b> Unknown							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b> <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town) (County) (State)</b>							
<b>21. I certify that</b> <b>NO</b> (this hospital) attended the deceased from <b>Oct. 14, 1961</b> , to <b>Nov. 5, 1961</b> that <b>NO</b> (we) last saw the deceased alive on <b>Nov. 5, 1961</b> , and that death occurred at <b>A.M.</b> , from the causes and on the date stated above.							
<b>22a. SIGNATURE</b> <b>Donald W. Stewart</b> M.D.				<b>22b. DATE SIGNED</b> <b>11/5/61</b>			
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>DONALD W. STEWART, M.D.</b>				<b>22d. ADDRESS</b> <b>3900 Loch Raven Blvd. VAH Baltimore, Md. FORT HOWARD DIVISION</b>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>11-7-61</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Oaklawn Cemetery</b>			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Charles S. Zeiler</b>		<b>24b. ADDRESS</b> <b>6224 Eastern Ave. Balto. Maryland</b>		<b>25a. REC'D BY REGISTRAR</b> <b>NOV 7 '61</b>			
<b>25b. REGISTRAR'S SIGNATURE</b> <b>Charles S. Zeiler</b>		<b>25c. LOCATION</b> (City, town or county) (State) <b>Baltimore Co., Maryland</b>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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12-5-11

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. See 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Item 1c, Film G301 11/20/61 iwc

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY in 1b <b>2 months</b> <b>13 days</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Baltimore 29, Md.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Spring Grove State Hospital</b>						e. STREET ADDRESS <b>601 Denison St.</b>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Andrew</b>		First		Middle		Last <b>Bayer</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>11</b> Year <b>19 61</b>	
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1-4-1870</b>		9. AGE (In years last birthday) <b>91</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Sales Rep.</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Germany</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		IF UNDER 1 YEAR Months Days Hours Min.	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>Unknown</b>		16. SOCIAL SECURITY NO. <b>215-18-702</b>		17. INFORMANT Address <b>Records: Spring Grove State Hospital</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchial Pneumonia</b> 422.1 DUE TO (b) <b>Chronic Cardio-vascular Disease</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO (c) <b>unknown</b>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Nilot prostatic enlargement Polomyelitis in past.</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)		21. I certify that (I) (this hospital) attended the deceased from....., 19....., to....., 19....., that (I) (we) last saw the deceased alive on.....19....., and that death occurred at.....M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Gertrude J. Fleischmann</b>		M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>11.11.1961</b>			
22c. PHYSICIAN'S NAME (Type) <b>GERTRUDE J. FLEISCHMANN</b>		22d. ADDRESS <b>Spring Grove State Hospital Catonsville, Maryland</b>		23a. NAME OF CEMETERY OR CREMATORY <b>Edmondson</b>		23b. DATE THEREOF <b>11/14/61</b>		23c. LOCATION (City, town or county) (State) <b>Baltimore 29, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Witzke &amp; Co.</b>		ADDRESS <b>4401 Edmondson</b>		25a. REC'D BY REGISTRAR DATE <b>NOV 14 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

12240

12226

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> <u>MARYLAND</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>									
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Carney</u>		c. LENGTH OF STAY IN 1b <u>34</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Carney</u>		d. STREET ADDRESS <u>9401 Old Harford Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>9401 Old Harford Road</u>				d. STREET ADDRESS <u>9401 Old Harford Road</u>									
<b>3. NAME OF DECEASED</b> (Type or print) <u>Joseph S. Bechtel</u>				<b>4. DATE OF DEATH</b> Month <u>11</u> Day <u>21</u> Year <u>1961</u>									
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-3-1881</u>		9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Marine Engineer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>				11. BIRTHPLACE (County & State, or foreign country) <u>Phila. Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>			
13. FATHER'S NAME <u>Charles Betchel</u>				14. MOTHER'S MAIDEN NAME <u>Deborah Smallwood</u>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>214-14-3620</u>		17. INFORMANT Address <u>Mr Charles Bechtel 414 Milford Road (8)</u>							
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Severe Gastro-Intestinal Hemorrhage</u> <u>200.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Retinoblastoma Cell Sarcoma</u> (c) <u>  </u> DUE TO (e), stating the underlying cause last.												INTERVAL BETWEEN ONSET AND DEATH <u>  </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>									
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) <u>  </u> (County) <u>  </u> (State) <u>  </u>							
21. I certify that (I) (this hospital) attended the deceased from <u>11/20</u> , 19 <u>61</u> , to <u>11/21</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>11/20</u> , 19 <u>61</u> , and that death occurred <u>11/21</u> , 19 <u>61</u> , from the causes and on the date stated above.													
22a. SIGNATURE <u>Donald W. Mintzer</u>				M.D. <u>  </u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>11/23/61</u>					
22c. PHYSICIAN'S NAME (Type) <u>DONALD W. MINTZER</u>				22d. ADDRESS <u>3009 EVERGREEN AVE. BALTO 14</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11-24-1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>		23d. LOCATION (City, town or county) <u>Baltimore</u>		(State) <u>Maryland</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>Lassahn Funeral Home 7401 Belair Road</u>				ADDRESS <u>  </u>		25a. REC'D BY REGISTRAR <u>  </u>		25b. REGISTRAR'S SIGNATURE <u>  </u>					





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12241

Reg. Dis. No. 227

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> <span style="float: right;">b. COUNTY <u>Baltimore</u></span>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodlawn</u>		c. LENGTH OF STAY IN 1b 		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Woodlawn</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2647 West Park Drive</u>				d. STREET ADDRESS <u>2647 West Park Drive</u>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>William Franklin Becker</u>				<b>4. DATE OF DEATH</b> Month <u>Nov.</u> Day <u>22</u> , Year <u>1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>June 19, 1912</u>		9. AGE (In years last birthday) <u>47</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Loader</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self Test Foods</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>			
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>William Becker</u>					
14. MOTHER'S MAIDEN NAME <u>Louisa ?</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>					
16. SOCIAL SECURITY NO. 		17. INFORMANT <u>Mrs Myrtle M. Becker</u> Address <u>2647 West Park Dr.</u>					
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>  </u> (c) <u>  </u> DUE TO (a), stating the underlying cause last. (c) <u>  </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Sept. 51 had resection of stomach due to ulcer non malignant</u> <u>results good. Well healed no trouble since operation</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>19</u>					
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Geo. S. M. Kieffer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>Nov. 22, 1961</u>			
EXAMINER'S NAME (Type) <u>Geo. S. M. Kieffer M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		1010 Leeds Ave (29)			
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		22a. BURIAL-CREATION, REMOVAL (Specify) <u>Nov 25, 1961</u>					
22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Northlawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Pickens &amp; Sons</u>		ADDRESS <u>Baltimore Md.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 27 '61</u>			
24b. REGISTRAR'S SIGNATURE <u>Wm. J. Pickens</u>							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12341

(M)

NAME OF DECEASED		SEX		AGE		DATE OF DEATH	
JAMES M. JONES		MALE		45		JAN 15 1950	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
1234 E. MAIN ST. BALTIMORE, MD.		Carpenter		Myocardial Infarction		Natural	
PLACE OF DEATH		HOSPITAL		DATE OF EXAMINATION		TIME OF EXAMINATION	
Home		St. Mary's Hospital		Jan 16 1950		10:00 AM	
PREVIOUS ILLNESS		HISTORY		PHYSICAL EXAMINATION		LABORATORY EXAMINATIONS	
None		Patient was well until 1 week before death when he began to feel chest pain and shortness of breath.		No significant findings.		None.	
MEDICAL HISTORY		SOCIAL HISTORY		PATHOLOGICAL FINDINGS		MICROSCOPIC FINDINGS	
None.		Patient was a heavy smoker (2 packs per day) and occasional drinker.		Coronary atherosclerosis with 75% obstruction of the left anterior descending artery.		None.	
FAMILY HISTORY		EDUCATION		TREATMENT		POST-MORTEM EXAMINATION	
None.		High School Graduate		None.		None.	
SIGNATURE OF EXAMINER		DATE		PLACE		TITLE	
J. M. Smith, M.D.		Jan 16 1950		Baltimore, Md.		Medical Examiner	

James M. Jones

1. Name of Deceased  
2. Sex  
3. Age  
4. Date of Death  
5. Residence  
6. Occupation  
7. Cause of Death  
8. Manner of Death  
9. Place of Death  
10. Hospital  
11. Date of Examination  
12. Time of Examination  
13. Previous Illness  
14. History  
15. Physical Examination  
16. Laboratory Examinations  
17. Medical History  
18. Social History  
19. Pathological Findings  
20. Microscopic Findings  
21. Family History  
22. Education  
23. Treatment  
24. Post-Mortem Examination  
25. Signature of Examiner  
26. Date  
27. Place  
28. Title

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages (pages 1 and 2) and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/60

MARYLAND STATE DEPARTMENT OF HEALTH															
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND															
12242 CERTIFICATE OF DEATH 12228															
Item 1c, Film G302 12/4/61 ink															
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>				b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN 1b <b>23 days</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>3212 Strickland Street</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Bertha Mae Belt</b>				4. DATE OF DEATH Month Day Year <b>November 23 1961</b>				a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Dec. 12, 1891</b>		9. AGE (In years last birthday) <b>69 yrs.</b>		IF UNDER 1 YEAR Months Days <b>69</b>		IF UNDER 24 HRS. Hours Min. <b>69</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife Attendant</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Bath Com. Balto. City</b>				11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
13. FATHER'S NAME <b>Nickolus Kemp</b>				14. MOTHER'S MAIDEN NAME <b>Olita Hunter</b>											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>unknown</b>				16. SOCIAL SECURITY NO. <b>214-40-5836</b>				17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>260X Premia</b> DUE TO (b) <b>Acute glomerulo nephritis</b> DUE TO (c) <b>Dialysis Melitus</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Arterio-sclerotic Cardiovascular Disease</b>												INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Baltimore</b>		(County) <b>Baltimore</b>		(State) <b>Maryland</b>			
21. I certify that (1) (this hospital) attended the deceased from <b>Nov. 9</b> , 19 <b>61</b> to <b>Nov 23</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>11-23-61</b> , 19 <b>61</b> , and that death occurred at <b>2:50 PM</b> , from the causes and on the date stated above.															
22a. SIGNATURE <b>Maurice J. Van Besien</b>				M.D. <b>MAURICE J. VAN BESIE</b>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>Nov 23, 61</b>					
22c. PHYSICIAN'S NAME (Type) <b>MAURICE J. VAN BESIE</b>				22d. ADDRESS <b>SPRING GROVE STATE HOSPITAL</b> <b>Catonsville 28, Maryland</b>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>Nov. 27, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Western</b>				23d. LOCATION (City, town or county) <b>Baltimore, Maryland</b>					
24. FUNERAL DIRECTOR'S SIGNATURE <b>Burgee Funeral Home</b>				ADDRESS <b>3631 Falls Road, Baltimore</b>				25a. REC'D BY REGISTRAR <b>NOV 27 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Thomas</b>					

15012

15012

(M)

(1)

Attendant Wash Co. Fresno, Calif.

21-10-53

Robert M. Miller  
West of Fresno  
Fresno

Active-Active California Bureau

Nov 53

11-2-51

Nov 53

Information, Bureau

Nov. 27, 1951

Nov. 27, 1951

Nov. 27, 1951

Engineer Bureau Home 3011 Santa Monica, Baltimore

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12243

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 12229

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE - 19 -</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>MD</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SPARROWS POINT</b>		c. LENGTH OF STAY IN 1b <b>17 mo -</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>RIO. BOX 391.</b>		d. STREET ADDRESS <b>#1</b>	
3. NAME OF DECEASED (Type or print) <b>Wladyslaw First White Middle Last WALTER. BIALOSKORSKI</b>		4. DATE OF DEATH <b>NOV. 14 - 1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>APRIL - 19 - 1877</b>
9. AGE (In years last birthday) <b>84</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired , , , ,</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Tailor</b>	
11. BIRTHPLACE (State or foreign country) <b>POLAND.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>215-07-0045</b>	
17. INFORMANT <b>WANDA MACKIE</b> Address <b>ASIN #1.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>MYOCARDIAL FAILURE</b> DUE TO (c) <b>PULMONARY OEDEMA.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>15 yrs.</b> <b>6 hours.</b> <b>1/2 hour</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct 15, 1960</b> to <b>Nov. 14, 1961</b> , that I last saw the deceased alive on <b>Nov. 14, 1961</b> , and that death occurred at <b>8:30 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Louise N. Tollin</b> M.D.		ADDRESS (Street, city or town, state) <b>6908 N. P+ Rd. Baltimore - 19 - Md.</b>	
DATE SIGNED <b>11/14/61</b>			
PHYSICIAN'S NAME (Type) <b>LOUIS N. TOLLIN</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-18-1961</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer</b>		22d. LOCATION (City, town, or county) (State) <b>Belair Rd. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>JOHN J. DUDA</b> ADDRESS <b>7922 Wise Ave. 22, Md.</b>		24a. REC'D BY REGISTRAR <b>NOV 21 61</b> DATE	
		24b. REGISTRAR'S SIGNATURE <b>Catherine S. Harris</b>	

(M)

NAME OF DECEASED JAMES J. HANCOCK		AGE 45		SEX M	
DATE OF DEATH JAN 10 1901		PLACE OF DEATH HOME		CITY BOSTON	
CAUSE OF DEATH HEART DISEASE		DISEASE OR INJURY CORONARY ARTERY DISEASE		MANNER OF DEATH NATURAL	
SIGNATURE OF PHYSICIAN J. J. HANCOCK		SIGNATURE OF DECEASED JAMES J. HANCOCK		SIGNATURE OF WITNESSES J. J. HANCOCK	
DATE OF SIGNATURE JAN 10 1901		DATE OF SIGNATURE JAN 10 1901		DATE OF SIGNATURE JAN 10 1901	
LOCALITY BOSTON		COUNTY SUFFOLK		STATE MASSACHUSETTS	
REGISTRATION NO. 15213		DATE OF REGISTRATION JAN 10 1901		OFFICE OF REGISTRATION BOSTON	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12244

12230

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b> c. LENGTH OF STAY IN 1b <b>2 Days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Veterans Administration Hospital</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore 31</b> d. STREET ADDRESS <b>2018 Orleans Street</b>			
3. NAME OF DECEASED (Type or print) <b>CHARLES</b> First Middle Last <b>BIGGERMAN</b>				4. DATE OF DEATH Month Day Year <b>November 30 19 61</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		8. DATE OF BIRTH <b>August 11, 1886</b>	
9. AGE (In years last birthday) <b>75 yrs.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Receiving Clerk &amp; buyer Cannery</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>John E. Biggerman</b>				14. MOTHER'S MAIDEN NAME <b>Anna Schuehle</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW I</b>				16. SOCIAL SECURITY NO. <b>212-07-8992</b>			
17. INFORMANT <b>Clinical Records, VAH, Baltimore 18, Maryland</b> <b>Fort Howard Division</b>				Address <b>Baltimore 18, Maryland</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CONGESTIVE HEART FAILURE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>BRONCHOPNEUMONIA</b> (c) <b>CHRONIC EMPHYSEMA</b>						INTERVAL BETWEEN ONSET AND DEATH <b>RECENT</b> <b>UNKNOWN</b> <b>UNKNOWN</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>ABDOMINAL ANEURYSM</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from <b>November 28, 1961</b> , to <b>November 30, 1961</b> that (X) (we) last saw the deceased alive on <b>November 30, 1961</b> , and that death occurred at <b>A.M.</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>John D. Talbert, M.D.</b> M.D.				22b. DATE <b>11/30/61</b>			
22c. PHYSICIAN'S NAME (Type) <b>JOHN D. TALBERT, M.D. Acting Chief, Medical Service, Fort Howard Division</b>				22d. ADDRESS <b>VAH, Baltimore 18, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>December 2/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Saint Matthews Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore County, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Phillip Herwig &amp; Sons</b> ADDRESS <b>Phillip Herwig &amp; Sons, 2024 Orleans St., Balto. Md.</b>				25a. REC'D BY REGISTRAR <b>DEC 4 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

15280

15281



Fort Howard

Veterans Administration Hospital

Fort Ord, California

CHARGE

PROBATION

November 30

White

November 11, 1960

Recovery Check & Paper, California

John E. McGowan

Clinton, Florida, VAN, Headquarters, Maryland  
Fort Howard Division

11-07-60

CONSTRUCTIVE MIND EXERCISE

11-07-60

PROBATION

CHURCH SERVICE

ALCOHOLIC DRUGS

November 30

November 30

November 30

Fort Howard Division  
November 30

November 30  
Fort Howard Division

November 30  
Fort Howard Division

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12245

Reg. Dist. No. 2231

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltonville</u>		c. LENGTH OF STAY in 1b <u>3 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Summit Nursing Home</u>		e. STREET ADDRESS <u>2502 Maryland Ave</u>	
3. NAME OF DECEASED (Type or print) <u>George A. Blake</u>		4. DATE OF DEATH <u>Nov. 20</u> 19 <u>61</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 17, 1897</u>
9. AGE (In years last birthday) <u>64</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bldg. Contractor</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S. A.</u>			
13. FATHER'S NAME <u>George Blake</u>		14. MOTHER'S MAIDEN NAME <u>Mary Moulton</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-102975</u>	
17. INFORMANT <u>Charles R. Blake</u>		Address <u>2502 Maryland Avenue</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO (b) <u>Myocarditis</u> DUE TO (c) <u>Alcoholism</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Geo. S. M. Kieffer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>Nov 20 61</u>	
EXAMINER'S NAME (Type) <u>GEO. S. M. KIEFFER MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>1010 Leade Av</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11-24-61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook, Inc., 1217 St. Paul Street, Baltimore</u>		ADDRESS	
24a. REC'D BY REGISTRAR <u>OV 21 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12246

Reg. Dist. No. 12232

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>BALTO.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL BALTO.</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>8510 OLD HARFORD RD</b>				d. STREET ADDRESS <b>8510 OLD HARFORD RD.</b>			
3. NAME OF DECEASED (Type or print) <b>HENA</b> First <b>MAGDALENA</b> Middle <b>BLAKLEY</b> Last				4. DATE OF DEATH Month <b>NOV</b> Day <b>29</b> Year <b>1961</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7 JULY 1956</b>	
9. AGE (In years last birthday) <b>66</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWORK</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>		11. BIRTHPLACE (State or foreign country) <b>BALTO. MD.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>JOHN GUILTA</b>				14. MOTHER'S MAIDEN NAME <b>BARBARA DEITZ</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>DAUGHTER</b> Address <b>MRS. CLARA LANCE (SAME)</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL VASCULAR Accident</b> <b>593X</b> DUE TO <b>HCVD.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Renal Disease</b> (c) <b>Renal Disease</b>						INTERVAL BETWEEN ONSET AND DEATH <b>1-2 hrs.</b> <b>undet</b> <b>undet</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>John C. Hyle</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>JOHN C. HYLE</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
DATE SIGNED <b>11-29-61</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>12-2-1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>HOLY REDEEMER</b>		22d. LOCATION (City, town, or county) (State) <b>BALTO. MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. Walter Conklin</b>				ADDRESS <b>5444 BELAIR RD.</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 1 '61</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kneale</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF MASSACHUSETTS  
DEPARTMENT OF HEALTH



1924  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, 18

Form with multiple sections for medical examination and death certification, including fields for name, age, sex, cause of death, and examiner's signature.

NAME: John J. Smith  
AGE: 45 SEX: M  
RESIDENCE: 123 Main St, Boston, Mass.  
CAUSE OF DEATH: Myocardial Infarction  
EXAMINER'S SIGNATURE: [Signature]  
DATE: Jan 15, 1924



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MAY 1961  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
12233

1. PLACE OF DEATH a. COUNTY <b>Baltimore County</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Wilson, Maryland</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring 1523-2</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Mt. Wilson State Hospital</b>				d. STREET ADDRESS <b>9202 Whitney St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Myrtle</b> Middle <b>Bohner</b> Last <b>Bohner</b>				4. DATE OF DEATH Month <b>11</b> Day <b>15</b> Year <b>1961</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12/20/1877</b>		9. AGE (In years lost birthday) yrs. <b>83</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Fearnow</b>				14. MOTHER'S MAIDEN NAME <b>Lane Hoffman</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Hospital Records, Mt. Wilson State Hospital</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiac Disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>420.0</b> (c) <b>2 yrs + (over)</b>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Moderately Advanced Pulmonary Tuberculosis</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>5/19</b> 19 <b>61</b> to <b>11/15</b> 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>11/15</b> 19 <b>61</b> , and that death occurred at <b>1256 PM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Wm. Newcomer</b>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>11/15/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Wm. Newcomer, M.D., Superintendent</b>				22d. ADDRESS <b>Mt. Wilson State Hospital, Mt. Wilson, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>11/17/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Union Chapel</b>		23d. LOCATION (City, town, or county) (State) <b>Berkeley Springs, W. Va.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Parks-Johnson Co.,</b> <b>C. E. Johnson</b>				25a. REC'D BY REGISTRAR <b>DATE</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

1528

CERTIFICATE OF DEATH

1528

(M)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Be 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it shall be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Balto.</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Halethorpe</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>House In The Pines</b>		d. STREET ADDRESS <b>5563 Oregon Ave.</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>MARY E. BORING</b>		4. DATE OF DEATH Month Day Year <b>Nov. 4, 1961</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 31, 1890</b>
9. AGE (In years last birthday) <b>71</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Md.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Luther Myers</b>		14. MOTHER'S MAIDEN NAME <b>Minerva Fogle</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Geo. H. Boring</b>		Address <b>5563 Oregon Ave.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>260X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized arteriosclerosis</b> DUE TO (c) <b>Diabetes mellitus</b>		INTERVAL BETWEEN ONSET AND DEATH <b>30 min.</b> <b>Insult</b> <b>5 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cerebrovascular Thrombosis</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Aug 15, 1961</b> to <b>Nov 4, 1961</b> , that (I) (we) last saw the deceased alive on <b>Nov 2, 1961</b> , and that death occurred at <b>2:58 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Bradley Langhast</b> M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22b. DATE SIGNED		22d. ADDRESS	
22c. PHYSICIAN'S NAME (Type)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/7/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>United Brethren Cem</b>		23d. LOCATION (City, town or county) (State) <b>Thurmont, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Howard H. Hubbard</b>		25a. REC'D BY REGISTRAR <b>NOV 6 '61</b>	
ADDRESS <b>4107 Wilkens Ave.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>	

VR A15 (4)  
15M 9/60

(M)

Balto.

Casonville

House In The Pines

MARY E. BORING

W

housewife

father Myers

no none

AUG. 31, 1890

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Minerva Lodge

Geo. H. Boring 5503 Oregon Ave.

5503 Oregon Ave.

Kalethorpe

Mo.

Balto.

1883

Serial 11761

United Brethren Com

Thomson, Mo.

Howard H. Hubbard #107 Wilkens Ave.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12249

CERTIFICATE OF DEATH

12235

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>X103 Shealey Avenue</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Towson Convalescent Home</b>		d. STREET ADDRESS <b>Towson</b>	
3. NAME OF DECEASED (Type or print) <b>AMANDA BORNMILLER</b>		4. DATE OF DEATH Month <b>November</b> Day <b>25</b> Year <b>1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Unknown 1874 app. 87 yrs.</b>
9. AGE (In years last birthday) <b>87</b>		IF UNDER 1 YEAR Months <b>87</b> Days <b>87</b> Hours <b>87</b> Min. <b>87</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Unknown</b>	
14. MOTHER'S MAIDEN NAME <b>Unknown</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	
16. SOCIAL SECURITY NO. <b>213-40-1190</b>		17. INFORMANT <b>Mrs. John Herzog, 101 Shealey Ave., Towson, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>myocardial infarction</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Generalized arteriosclerosis</b> (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>15 minutes</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>9</b> a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <b>November 1961</b> to <b>Nov 25</b> , 1961, that (1) (we) last saw the deceased alive on <b>Nov 25</b> , 1961, and that death occurred at <b>4:30</b> A.M. from the causes and on the date stated above.			
22a. SIGNATURE <b>George T. Gilmore</b>		22b. DATE SIGNED <b>Nov 25</b>	
22c. PHYSICIAN'S NAME (Type) <b>GEORGE T. GILMORE</b>		22d. ADDRESS <b>Lutherville, Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Nov. 28, 1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Prospect Hill Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Towson, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>John Burns' Sons, Towson, Maryland</b>		25a. REC'D BY REGISTRAR DATE <b>DEC 1 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>			

(M)

(K)

12882

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12882

12882

Town

103 Shelby Ave

Town

Town (overseas) 11-10

x

November 25, 1961

BOBWHITE

WYATT

x

Unknown 1944 app. 87

Female white

USA

Maryland

Old Hope

housewife

Unknown

Unknown

21-40-1190 Mrs. John Nelson, 101 Shelby Ave., Town, Md.

None

No

Town, Maryland

Nov. 26, 1961 Prospect Hill Cemetery

Burial

John Nelson, 503, Town, Maryland



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.  
VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
12230  
12236  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <b>Illinois</b> b. COUNTY <b>Cook</b> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lutherville</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oak Park</b> <b>51X-3</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>1218 Longford Road</b>				d. STREET ADDRESS <b>728 N. Marion Street</b>			
3. NAME OF DECEASED (Type or print) <b>LUCY FLORENCE BROOKHOUSE</b>				4. DATE OF DEATH Month <b>November</b> Day <b>22</b> Year <b>19 61</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>December 4, 1888</b>	
9. AGE (In years last birthday) <b>72</b> yrs.		IF UNDER 1 YEAR Months <b>7</b> Days <b>22</b>		IF UNDER 24 HRS. Hours <b>11</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>London, England</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>John Smith</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>			
17. INFORMANT <b>Mrs. Wm. B. Mosher, 1218 Longford Rd. Lutherville</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute myocardial infarction</b> <b>420.1</b> DUE TO (b) <b>arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>30 minutes</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <b>July 1, 1960</b> to <b>Nov. 21, 1961</b> , that (2) (we) last saw the deceased alive on <b>Nov. 21, 1961</b> , and that death occurred at <b>11:00 AM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>George T. Gilmore</b> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>GEORGE T. GILMORE</b>				22d. ADDRESS <b>Lutherville, Md</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal/Burial Nov. 23, 1961</b>		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Emblem Cem.</b>		23d. LOCATION (City, town or county) (State) <b>Elmhurst, Illinois</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>John Burns' Sons, Towson, Maryland</b>				ADDRESS		25a. REC'D BY REGISTRAR <b>NOV 27 '61</b>	
				25b. REGISTRAR'S SIGNATURE <b>Arthur S. House</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>300 N. Rolling Road</b>					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b> d. STREET ADDRESS <b>300 N. Rolling Road</b> a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <b>Stephen Bonsal Brooks Jr.</b>					4. DATE OF DEATH <b>November 4 1961</b>						
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 16, 1916</b>		9. AGE (In years last birthday) <b>45</b> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sales Manager</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Concrete</b>			11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>S. Bonsal Brooks Sr.</b>					14. MOTHER'S MAIDEN NAME <b>Priscilla Bohlem</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes give war or dates of service) <b>WW 2</b>					17. INFORMANT <b>Mrs Natalie Brooks, 300 N. Rolling Rd.</b> Address						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Epidural Symplocoma - Spinal Cord</b> 202.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <b>Sept 3, 1961</b> to <b>Nov 4, 1961</b> , that (I) (we) last saw the deceased alive on <b>Nov 3, 1961</b> , and that death occurred at <b>3:30 AM</b> , from the causes and on the date stated above.											
22a. SIGNATURE <b>Walter B. Buck</b>					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>11/4/61</b>				
22c. PHYSICIAN'S NAME (Type) <b>WALTER B. BUCK</b>					22d. ADDRESS <b>18 E. Sagon St, Balt - 2 Md</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>Nov. 6, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Thomas' Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Garrison Forest Maryland</b>					
24. FUNERAL DIRECTOR'S SIGNATURE <b>Henry W. Jenkins &amp; Sons Co.</b> ADDRESS <b>4905 York Road Balt 12 Md.</b>					25a. REC'D BY REGISTRAR <b>NOV 7 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>				

VR A15 (4)  
15M 9/60

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may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12252

**CERTIFICATE OF DEATH**

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>7 yrs.</b>		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>15 Somerset Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Baltimore</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		d. STREET ADDRESS <b>15 Somerset Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Bessie</b> Middle <b>Estelle</b> Last <b>Brosenne</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>15</b> Year <b>1961</b>		5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. B. DATE OF BIRTH <b>1887</b>		9. AGE (In years lost birthday) <b>73 1/4</b> yrs.		10. IF UNDER 1 YEAR Months <b>1</b> Days <b>15</b> Hours <b>15</b> Min.		11. IF UNDER 24 HRS. Months <b>1</b> Days <b>15</b> Hours <b>15</b> Min.		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>William Knott</b>	
14. MOTHER'S MAIDEN NAME <b>Jane Elliott</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mr. Donald G. Brosenne 15 Somerset Rd.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO <b>420.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive Heart Disease</b> DUE TO <b>Anteriorly located Heart Disease</b> (c) <b>Aortic aortic insufficiency</b>	
19. INTERVAL BETWEEN ONSET AND DEATH <b>1 hr.</b>		20. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>10 yrs.?</b>		21. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>5 yrs.</b>		22. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>10 yrs.?</b>		23. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>5 yrs.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <b>Aug 20</b> 19 <b>59</b> to <b>Nov 15</b> 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>Nov 15</b> 19 <b>61</b> , and that death occurred at <b>6:29 PM</b> , from the causes and on the date stated above.		22a. SIGNATURE <b>John N. Snyder M.D.</b>		22b. DATE SIGNED <b>Nov 16, 1961</b>		22c. PHYSICIAN'S NAME (Type) <b>John N. Snyder M. D.</b>	
22d. ADDRESS <b>6348 Frederick Rd. Catonsville - 28, Md.</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/18/1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. John's Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Ellicott City, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Easton Funeral Home</b>		25a. REC'D BY REGISTRAR <b>NOV 20 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>		25c. REGISTRAR'S SIGNATURE		25d. REGISTRAR'S SIGNATURE	

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2nd of March 1914



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12253

## CERTIFICATE OF DEATH

12239

1. NAME OF DECEASED  
(Type or Print)

*Anna Gertrude Brown*

2. DATE OF DEATH

*Nov. 5, 1961*

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF  
HOSPITAL OR  
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

*House of Pines Nursing Home*

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

*Md.*

C. CITY OR TOWN

(If outside city limits, write RURAL and give township)

*Baltimore*

D. STREET ADDRESS

(If rural, give location)

*637 McKewin Ave.*

5. SEX

*female*

6. COLOR OR RACE

*white*

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

*married*

8. DATE OF BIRTH

*8-5-1880*

9. AGE (In years  
last birthday)

*81*

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

10.A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even  
if retired)

*housewife*

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

*Maryland*

12. CITIZEN OF  
WHAT COUNTRY?

*USA*

13. FATHER'S NAME

*Robert J. Brown*

14. MOTHER'S MAIDEN NAME

*Anne O'Grady*

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

*Timothy S. Brown*

*same*

18.

### CAUSE OF DEATH

I  
DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

*420.1*

(A) *Coronary Thrombosis*

DUE TO

INTERVAL BETWEEN  
ONSET AND DEATH

*1 da.*

### ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) *Hypertensive Cardio-Vascular Dis.*

DUE TO

*15 yr.*

(C) \_\_\_\_\_

### II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

IF OPERATION WAS RELATED TO  
CAUSE OF DEATH, ENTER IN  
PART I OR PART II

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

2D. AUTOPSY?

YES ☐

NO ☒

22. I certify that (I) (this hospital) attended the deceased from

*11-5-*

*19 61*

that (I) (we) last saw the deceased alive on

*11-3-*

*19 57*

*19 57*

and that in (my) (our) opinion death occurred at *2:15 PM* m., from the causes and on the date stated above.

23A. SIGNATURE

*William K. Gallagher*

23b. ADDRESS

M. D.

*6209 Frederick Ave. Balt 28*

23c. DATE SIGNED

*11-6-61*

24A. BURIAL, CREMATION,  
REMOVAL (Specify)

24b. DATE

24c. NAME OF CEMETERY OR CREMATORY

24d. LOCATION

(City, town, or county)

(State)

*burial*

*11-8-61*

*New Cathedral Cemetery*

*Baltimore, Md.*

25A. DATE REC'D BY HEALTH DEPT.

25b. NAME OF REGISTRAR

25c. FUNERAL DIRECTOR

ADDRESS

*NOV 7 1961*

*Nov 8 1961*

*Leonard J. Ruck 5305 Hartford Rd.*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

15288

15288

1. NAME OF PARTY		2. COUNTY	
3. NAME OF PARTY		4. COUNTY	
5. NAME OF PARTY		6. COUNTY	
7. NAME OF PARTY		8. COUNTY	
9. NAME OF PARTY		10. COUNTY	
11. NAME OF PARTY		12. COUNTY	
13. NAME OF PARTY		14. COUNTY	
15. NAME OF PARTY		16. COUNTY	
17. NAME OF PARTY		18. COUNTY	
19. NAME OF PARTY		20. COUNTY	
21. NAME OF PARTY		22. COUNTY	
23. NAME OF PARTY		24. COUNTY	
25. NAME OF PARTY		26. COUNTY	
27. NAME OF PARTY		28. COUNTY	
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33. NAME OF PARTY		34. COUNTY	
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37. NAME OF PARTY		38. COUNTY	
39. NAME OF PARTY		40. COUNTY	
41. NAME OF PARTY		42. COUNTY	
43. NAME OF PARTY		44. COUNTY	
45. NAME OF PARTY		46. COUNTY	
47. NAME OF PARTY		48. COUNTY	
49. NAME OF PARTY		50. COUNTY	
51. NAME OF PARTY		52. COUNTY	
53. NAME OF PARTY		54. COUNTY	
55. NAME OF PARTY		56. COUNTY	
57. NAME OF PARTY		58. COUNTY	
59. NAME OF PARTY		60. COUNTY	
61. NAME OF PARTY		62. COUNTY	
63. NAME OF PARTY		64. COUNTY	
65. NAME OF PARTY		66. COUNTY	
67. NAME OF PARTY		68. COUNTY	
69. NAME OF PARTY		70. COUNTY	
71. NAME OF PARTY		72. COUNTY	
73. NAME OF PARTY		74. COUNTY	
75. NAME OF PARTY		76. COUNTY	
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89. NAME OF PARTY		90. COUNTY	
91. NAME OF PARTY		92. COUNTY	
93. NAME OF PARTY		94. COUNTY	
95. NAME OF PARTY		96. COUNTY	
97. NAME OF PARTY		98. COUNTY	
99. NAME OF PARTY		100. COUNTY	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

12254

12240

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b> c. LENGTH OF STAY IN 1b <b>209 Days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Veterans Administration Hospital</b>			<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Kent</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b> d. STREET ADDRESS <b>Route #3</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
<b>3. NAME OF DECEASED</b> (Type or print) <b>EDWARD E. BROWN</b>			<b>4. DATE OF DEATH</b> Month <b>November</b> Day <b>19</b> Year <b>1961</b>		
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>March 7, 1892</b>		<b>9. AGE</b> (In years last birthday) <b>69</b> yrs. IF UNDER 1 YEAR: Months <b>69</b> Days <b>69</b> IF UNDER 24 HRS.: Hours <b>69</b> Min. <b>69</b>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Waterman - Retired</b>			<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Chestertown, Maryland</b>
<b>13. FATHER'S NAME</b> <b>William E. Brown</b>			<b>14. MOTHER'S MAIDEN NAME</b> <b>Mary C. Stoops</b>		
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>Yes</b> (If yes give war or dates of service) <b>WW I</b>			<b>16. SOCIAL SECURITY NO.</b> <b>218-20-4216</b>		
<b>17. INFORMATION</b> <b>Clinical Records, VAH, Baltimore 18, Maryland</b>			<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>HODGKIN'S DISEASE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>201X BRONCHOPNEUMONIA, TERMINAL</b> DUE TO (b) <b>RECENT</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>UNKNOWN</b>		
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>			<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)		
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>			<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)			<b>20f. (City or town)</b> (County) (State)		
<b>21. I certify that</b> <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>April 24, 1961</b> , to <b>November 19, 1961</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Nov. 19, 1961</b> , and that death occurred at <b>P.M.</b> , from the causes and on the date stated above.					
<b>22a. SIGNATURE</b> <i>Marvin Williams</i>			<b>22b. DATE SIGNED</b> <b>11/20/61</b>		
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>Marvin Williams</b>			<b>22d. ADDRESS</b> <b>VAH, BALTO. 18, MD., FT. HOWARD DIVISION</b>		
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>11/24/61</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Chester Cemetery</b>		<b>23d. LOCATION</b> (City, town or county) (State) <b>Chestertown, Maryland</b>
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <i>Marvin Williams</i>			<b>25a. REC'D BY REGISTRAR</b> <b>NOV 27 '61</b>		
<b>25b. REGISTRAR'S SIGNATURE</b> <i>Arthur S. Harris</i>					

VR A15 (4)  
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Veterans Administration Hospital

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12255

12241

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL - RANDALLSTOWN</b> c. LENGTH OF STAY IN 1b <b>2 1/2 YEARS</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>3700 DOWNEYDALE DRIVE 1</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTO</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL ROCKDALE</b> d. STREET ADDRESS <b>3521 MILLVALE RD</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MARGUERITE</b> Middle <b>VIRGINIA</b> Last <b>BUCK</b>		4. DATE OF DEATH Month <b>November</b> Day <b>8</b> Year <b>1961</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/26/1894</b>
9. AGE (In years last birthday) <b>67</b> yrs.		10. IF UNDER 1 YEAR Months <b>2</b> Days <b>1</b> Hours <b>1</b> Min.	11. IF UNDER 24 HRS. Months <b>2</b> Days <b>1</b> Hours <b>1</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWORK</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOUSEWORK</b>	
11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>MR. KIDZMAUL</b>		14. MOTHER'S MAIDEN NAME <b>TAWNEY Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>218-38-434</b>	
17. INFORMANT <b>MR. EMORY WHITTINGTON</b>		Address <b>3700 DOWNEYDALE DRIVE RANDALLSTOWN, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>433.0 ADAM STOKES SYNDROME</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <b>DEGENERATIVE HEART DISEASE</b> (c) <b>CARDIAL ASTHMA</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 WEEKS</b> <b>2 MONTHS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>JUNE 11 1955</b> to <b>NOV 4 1961</b> , that (I) (we) last saw the deceased alive on <b>NOV 4 1961</b> , and that death occurred at <b>7:40 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Edwin L. Pierpont</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>EDWIN L. PIERPONT, MD</b>		22d. ADDRESS <b>8204 LIBERTY RD - BALTO 7, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/10/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park</b>		23d. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Loring Byers</b>		25a. REC'D BY REGISTRAR <b>NOV 10 61</b>	
ADDRESS <b>8728 Liberty Road Randallstown, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Robert S. Young</b>	

15311

15311

(M)

(L)

CHICAGO



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. **12242**

12258

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Baltimore</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Baltimore County</b>	
c. LENGTH OF STAY IN 1b <b>6 months</b>		d. STREET ADDRESS <b>6401 No. Charles St., Baltimore</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>6401 North Charles St., Baltimore 12</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Mary Frances Calhoun (Sister Mary Ethelburg)</b>		4. DATE OF DEATH Month <b>November</b> Day <b>9</b> Year <b>1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 24, 1911</b>
9. AGE (In years last birthday) <b>50</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Religious teacher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Religious Order</b>	11. BIRTHPLACE (State or foreign country) <b>Boston, Massachusetts</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Joseph F. Calhoun</b>	
14. MOTHER'S MAIDEN NAME <b>Anna M. Shea</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <b>Sister Mary Ernest, S.S.N.D. Charles St. Balt.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>201X Respiratory Insufficiency</b> DUE TO (b) <b>Pulmonary Infiltration</b> DUE TO (c) <b>Hepatic Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs.</b> <b>8 mos.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Sept. 16, 1961</b> , to <b>November 9, 1961</b> , that I last saw the deceased alive on <b>November 8, 1961</b> , and that death occurred at <b>12:05 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Robert J. Mahon</b>		ADDRESS (Street, city or town, state) <b>602 E. Joppa Road</b> DATE SIGNED	
PHYSICIAN'S NAME (Type) <b>Robert J. Mahon, M.D.</b>		Towson 4, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>November 11, 1961</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Villa Maria, Notch Cliff, Glenarm, Maryland</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James Henry W. &amp; Sons - York Road</b>		ADDRESS <b>4905</b> DATE <b>NOV 13 '61</b>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <b>Charles E. Hume</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## 21. PROMITTANT- ATACH TO THE ATTACHED STATE CHARTER.

2

10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12257

## CERTIFICATE OF DEATH

Reg. Dist. No. 12243

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7015 Yataruba Drive</u>		d. STREET ADDRESS <u>7015 Yataruba Drive</u>	
3. NAME OF DECEASED (Type or print) <u>FRED A CAPLAN</u>		4. DATE OF DEATH <u>11-24-1961</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-8</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Russia</u>	
11. BIRTH PLACE (State or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Seamore Applestein</u>		14. MOTHER'S MAIDEN NAME <u>Ester</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Reuben Caplan - son</u>	
17. INFORMANT <u>Reuben Caplan - son</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Sclerosis</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>General hypertensive C.V.H.D.</u> DUE TO (c) <u>12-year</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bronchitis Ectasis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb-4</u> , 19 <u>61</u> , to <u>Nov-21</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>Nov-21</u> , 19 <u>61</u> , and that death occurred at <u>11:30 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Dr. Herman Seidel</u>		ADDRESS (Street, city or town, state) <u>2404 Eutaw Place</u>	
PHYSICIAN'S NAME (Type) <u>HERMAN SEIDEL</u>		DATE SIGNED <u>11/26/61</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-26-61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Hebrew Young Men</u>		22d. LOCATION (City, town, or county) (State) <u>Balto Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Lewin</u>		ADDRESS <u>2100 Eutaw Place</u>	
24a. REC'D BY REGISTRAR <u>NOV 28 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thoma</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

12258

12244

1. PLACE OF DEATH e. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>84 Days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Veterans Administration Hospital</b>		d. STREET ADDRESS <b>Rural Route #1</b>	
3. NAME OF DECEASED (Type or print) <b>FRANCIS S. CAREY</b>		4. DATE OF DEATH Month <b>November</b> Day <b>30</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 18, 1895</b>
9. AGE (In years last birthday) <b>66</b> yrs.		IF UNDER 1 YEAR Months <b>23</b> Days <b>x</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Showell, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>William Carey</b>		14. MOTHER'S MAIDEN NAME <b>Julia Downes</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>Yes WW I</b>		16. SOCIAL SECURITY NO. <b>218-121-632</b>	
17. INFORMANT <b>Clinical Records, VAH, Baltimore 18, Maryland</b>		Address <b>Fort Howard Division</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of the lung</b> DUE TO (b) <b>163X</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Diabetes Mellitus</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Unknown</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>September 7, 1961</b> to <b>Nov. 30, 1961</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Nov. 30, 1961</b> , and that death occurred at <b>1:30 A.M.</b> from the causes and on the date stated above.		22a. SIGNATURE <b>John D. Talbert, M.D.</b> 22b. DATE SIGNED <b>11/30/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>JOHN D. TALBERT, M.D. Acting Chief, Medical Service</b>		22d. ADDRESS <b>Baltimore 18, Maryland</b> <b>Fort Howard Division</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/3/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Odd Fellows Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Bishopville, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Burbage Funeral Home, Berlin, Md.</b>		25a. REC'D BY REGISTRAR <b>DEC 4 '61</b> 25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	

2



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
M

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

12259

12245

1. PLACE OF DEATH a. COUNTY <u>Baltimore County</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>P. GEORGES</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Wilson, Maryland</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL WASHINGTON D.C. 11x2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Mt. Wilson State Hospital</u>				d. STREET ADDRESS <u>6501 D'ARCY ROAD</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM ROY CARL</u>				4. DATE OF DEATH Month Day Year <u>11-29-1961</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-30-1887</u>	
9. AGE (In years lost birthday) yrs. <u>74</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE PLASTERER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BUILDING</u>		11. BIRTHPLACE (State or foreign country) <u>WASHINGTON D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>THEODORE CARL</u>				14. MOTHER'S MAIDEN NAME <u>MARY ELLEN ROYER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>		17. INFORMANT Address <u>Hospital Records, Mt. Wilson State Hospital</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>FAR ADVANCED PULMONARY TUBERCULOSIS</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>PULMONARY EMPHYSEMA</u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>3-6-59</u> to <u>11-29-1961</u> , that (I) (we) last saw the deceased alive on <u>11-28-1961</u> , and that death occurred at <u>5 A.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>W. Newcomer</u>				22b. DATE SIGNED <u>11-29-61</u>			
22c. PHYSICIAN'S NAME (Type) <u>Wm. Newcomer, M.D., Superintendent</u>				22d. ADDRESS <u>Mt. Wilson State Hospital, Mt. Wilson, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12/4/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Bedar Hill</u>		23d. LOCATION (City, town or county) (State) <u>Suitland Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co. Washington D.C.</u>				25a. REC'D BY REGISTRAR <u>DEC 1 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

02

2

1

CERTIFICATE OF DEATH

1941

1941

1941

NAME OF DECEASED  
SEX  
AGE  
DATE OF BIRTH  
PLACE OF BIRTH  
DATE OF DEATH  
PLACE OF DEATH  
CAUSE OF DEATH  
MANNER OF DEATH  
OCCUPATION  
EDUCATION  
RELIGION  
MARRIAGE  
SINGLE  
MARRIED  
WIDOWED  
DIVORCED  
REMARKS

SIGNATURE OF PHYSICIAN  
SIGNATURE OF REGISTRAR  
SIGNATURE OF WITNESSES  
DATE  
PLACE

12260

12246

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>WORCESTER</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Wilson, Maryland</b>		c. LENGTH OF STAY IN 1b <b>22</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BERLIN</b>		d. STREET ADDRESS <b>22 X-2</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Mt. Wilson State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>GEORGE</b>		First <b>GEORGE</b>		Middle <b>FREEMAN</b>		Last <b>CARNEY</b>	
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>NEGRO</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF DEATH <b>11 4 19 61</b>	
9. AGE (In years lost birthday) <b>62</b> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>CONSTRUCTION</b>		10c. DATE OF BIRTH <b>9/18/1899</b>	
11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>CLARENCE T. CARNEY</b>		14. MOTHER'S MAIDEN NAME <b>MATTIE L. DARMOND</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>225-09-4318</b>		17. INFORMANT <b>Hospital Records, Mt. Wilson State Hospital</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: <b>163 X</b> IMMEDIATE CAUSE (a) <b>CARCINOMA OF LUNG</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>0 MONTHS</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Hour a. m. _____ p. m. _____ Month, Day, Year <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <b>9/21/1961</b> to <b>11/4/1961</b> , that (I) (we) last saw the deceased alive on <b>11/4/1961</b> and that death occurred at <b>A. M.</b> from the causes and on the date stated above.		22a. SIGNATURE <b>Wm. Newcomer</b>		22b. DATE SIGNED <b>11/4</b>		22c. PHYSICIAN'S NAME (Type) <b>Wm. Newcomer, M.D. Superintendent</b>	
22d. ADDRESS <b>Mt. Wilson State Hospital, Mt. Wilson, Md.</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		23b. DATE THEREOF <b>11-7-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore and</b>	
23d. LOCATION (City, town, or county) <b>Baltimore, Md.</b>		23e. NAME OF CEMETERY OR CREMATORY		23f. LOCATION (City, town, or county)		(State)	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Frank H. Howell</b>		ADDRESS <b>1218 E. 1st St.</b>		25a. REC'D BY REGISTRAR <b>NOV 8 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Charles S. Thomas</b>	

15360

(M)

15360

STATE OF CALIFORNIA

DEPARTMENT OF HEALTH

DATE OF BIRTH

SEX

RACE

HEIGHT

WEIGHT

EDUCATION

OCCUPATION

DATE OF DEATH

CAUSE OF DEATH

PLACE OF BIRTH

PLACE OF DEATH

DATE OF INTERVIEW

NAME OF INTERVIEWER

CHIEF OF BUREAU

DEPUTY CHIEF

ASSISTANT CHIEF

15360

15360

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12261

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b> c. LENGTH OF STAY IN 1b <b>23 Days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Veterans Administration Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Snow Hill</b> d. STREET ADDRESS <b>204 Petitt Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ISAAH --- CARR</b>		4. DATE OF DEATH Month <b>November</b> Day <b>29</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 11, 1908</b>
9. AGE (In years last birthday) <b>53</b> yrs.		IF UNDER 1 YEAR Months <b>53</b> Days <b>23</b> Hours <b>2</b> Min.	IF UNDER 24 HRS. Hours <b>23</b> Min. <b>2</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Saw Mill</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Albany, Georgia</b>
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>Monroe Carr</b>	
14. MOTHER'S MAIDEN NAME <b>Annie Smith</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW II</b>	
16. SOCIAL SECURITY NO. <b>217-28-3549</b>		17. INFORMANT <b>Clinical Records, VAH, Baltimore 18, Maryland</b> <b>Fort Howard Division</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF THE PANCREAS WITH METASTASES TO LIVER AND ABDOMEN</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>157X XXXX</b> DUE TO (c) <b>UNKNOWN</b>		INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that <b>10</b> (this hospital) attended the deceased from <b>Nov. 6</b> to <b>Nov. 29</b> , 1961, that <b>10</b> (we) last saw the deceased alive on <b>Nov. 29</b> , 1961, and that death occurred at <b>2:25</b> P.M. from the causes and on the date stated above.			
22a. SIGNATURE <b>Thomas F. Crahan</b> M.D.		22b. DATE <b>11/30/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>THOMAS F. CRAHAN</b>		22d. ADDRESS <b>M.D. VAH, BALTO 18 MD FT HOWARD DIVISION</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Dec. 2, 1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Baptist Church Cemetery</b>
23d. LOCATION (City, town or county) <b>Snow Hill, Maryland</b>		(State)	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Norman F. Harris, Snow Hill, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>DEC 5 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Harris</b>			





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 12248

12262

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Halethorpe</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Halethorpe X</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2020 Northeast Ave</u>		d. STREET ADDRESS <u>2020 Northeast Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>Harriett</u> Middle <u>Ellen</u> Last <u>Chambers</u>		4. DATE OF DEATH Month <u>NOVEMBER</u> Day <u>7</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-10-01</u>
9. AGE (In years lost birthday) <u>60</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>	11. BIRTHPLACE (State or foreign country) <u>Md</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>Benjamin Payne</u>	
14. MOTHER'S MAIDEN NAME <u>Liddia Wesley</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>  </u>		17. INFORMANT <u>James Chambers</u> Address <u>2015 Northeast Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL FAILURE</u> <u>170X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CARCINOMA OF RT. BREAST METASTAS</u> DUE TO (c) <u>CACHEXIA</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 MONTHS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>SEPT</u> , 19 <u>61</u> , to <u>7 NOV</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>7 NOV</u> , 19 <u>61</u> , and that death occurred at <u>8:05</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>George E. Grolegu</u>		ADDRESS (Street, city or town, state) <u>5608 Main St. Elkridge 27, Md</u>	
PHYSICIAN'S NAME (Type) <u>George E. Grolegu</u>		DATE SIGNED <u>11-10-61</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>  </u>	22b. DATE THEREOF <u>11-10-61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Western Star Cem</u>	22d. LOCATION (City, town, or county) (State) <u>Balto Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Sullivan Fun. Home - 1611-13 N. Arlington Av</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 10 '61</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur J. Hume</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

12203

(14)

1. NAME OF DECEASED <i>Charles D. H. Fisher</i>		2. SEX <i>Male</i>	
3. AGE <i>71</i>		4. DATE OF BIRTH <i>July 1, 1891</i>	
5. PLACE OF BIRTH <i>St. Louis, Mo.</i>		6. OCCUPATION <i>Retired</i>	
7. CAUSE OF DEATH <i>Heart Failure</i>		8. PLACE OF DEATH <i>Home</i>	
9. DATE OF DEATH <i>July 1, 1962</i>		10. TIME OF DEATH <i>10:00 AM</i>	
11. SIGNATURE OF PHYSICIAN <i>[Signature]</i>		12. SIGNATURE OF REGISTRAR <i>[Signature]</i>	
13. SIGNATURE OF WITNESSES <i>[Signature]</i>		14. SIGNATURE OF DECEASED <i>[Signature]</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. The law also requires that the death certificate be retained by the funeral director. After this certificate has been signed by the attending physician and completed, fill in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
12263						12249					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)					
a. COUNTY <b>Baltimore</b>						e. STATE <b>Maryland</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Severn</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Veterans Administration Hospital</b>						d. STREET ADDRESS <b>Box 306 Quarterfield Road</b>					
3. NAME OF DECEASED (Type or print) <b>(Served as WILLIAM CHEW) WILLIAM R. CHEW</b>						4. DATE OF DEATH <b>November 30 19 61</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>November 18, 1894</b>		9. AGE (In years last birthday) <b>67 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk - Retired</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Postal Service</b>				11. BIRTHPLACE (County & State, or foreign country) <b>Galena, Maryland</b>			
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>				13. FATHER'S NAME <b>William Chew</b>				14. MOTHER'S MAIDEN NAME <b>Catherine Peaker</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes WW I</b>				16. SOCIAL SECURITY NO. <b>WW I</b>				17. INFORMANT <b>Clinical Records, VAH, Baltimore 18, Maryland</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)				19. WAS AUTOPSY PERFORMED? <b>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></b>				INTERVAL BETWEEN ONSET AND DEATH <b>1 DAY +</b>			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>POSTEROLATERAL MYOCARDIAL INFARCTION</b> DUE TO <b>CORONARY OCCLUSION</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) (d) (e) (f) (g) (h) (i) (j) (k) (l) (m) (n) (o) (p) (q) (r) (s) (t) (u) (v) (w) (x) (y) (z)				PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>DIABETES MELLITUS</b>				20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20a. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>11/15/61 7:00 p.m.</b>				20b. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>11/15/61 7:00 p.m.</b>			
20d. (City or town) <b>Severn</b>				20e. (County) <b>Severn</b>				20f. (State) <b>Maryland</b>			
21. I certify that (a) (this hospital) attended the deceased from <b>11/15/61</b> to <b>11/30/61</b> , 19 <b>61</b> , that (b) (we) last saw the deceased alive on <b>11/30/61</b> , 19 <b>61</b> , and that death occurred at <b>7:00 p.m.</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>Sebastian Russo</b>						22b. DATE SIGNED <b>12/1/61</b>					
22c. PHYSICIAN'S NAME (Type) <b>SEBASTIAN RUSSO, M.D.</b>						22d. ADDRESS <b>VAH, BALTO. 18, MD., FT. HOWARD DIVISION</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>12-5-61</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cemetery</b>			
23d. LOCATION (City, town or county) <b>Baltimore 28, Maryland</b>				23e. REC'D BY REGISTRAR <b>Charles R. Law</b>				23f. REGISTRAR'S SIGNATURE <b>Charles R. Law</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Charles R. Law</b>						24. ADDRESS <b>802 Madison Ave. Baltimore Md.</b>					
24. DATE <b>DEC 6 '61</b>						24. SIGNATURE <b>Charles R. Law</b>					

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Service

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Box 300, Georgetown, Guyana

Voluntary Administration Hospital

(CHS)

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November 30, 1961

November 10, 1961

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U.S.A.

U.S. Postal Service, Guyana

Chief - Medical

Postmaster General

Medical Officer

Clinical Records, V.A. Hospital, Guyana

Postmaster General

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POSTMASTER GENERAL, GUYANA

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
12264						12250					
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Owings Mills</b> c. LENGTH OF STAY IN 1b <b>47 yrs.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Rosewood State Training School</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>1617 Baker Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Frances - A. Coffey</b>						4. DATE OF DEATH Month <b>11</b> Day <b>15</b> Year <b>19 61</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2/20/10</b>		9. AGE (In years last birthday) <b>51</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Dependent—never worked none</b>						10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) <b>Balto. City, Md.</b>		
13. FATHER'S NAME <b>James Joseph Coffey (D)</b>						14. MOTHER'S MAIDEN NAME <b>Margaret David (D)</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>						16. SOCIAL SECURITY NO. <b>none</b>			17. INFORMANT <b>Rosewood Records, Owings Mills, Md.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>500 X</b> (b) <b>Acute bronchitis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Mongolism with terminal Alzheimers Dementia</b>						INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b> <b>2 weeks</b>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that <del>it</del> (this hospital) attended the deceased from <b>11/22</b> , 19 <b>61</b> to <b>11/15</b> , 19 <b>61</b> , that <del>it</del> (we) last saw the deceased alive on <b>11/15</b> , 19 <b>61</b> , and that death occurred at <b>11:15 a.m.</b> the causes and on the date stated above.											
22a. SIGNATURE <b>Harry G. Butler</b> M.D.						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22b. DATE SIGNED <b>11/15/61</b>		
22c. PHYSICIAN'S NAME (Type) <b>Harry G. Butler, M.D.</b>						22d. ADDRESS <b>Rosewood Lane, Owings Mills, Maryland</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>11-16-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cemetery</b>			23d. LOCATION (City, town or county) (State) <b>Baltimore, Maryland</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Tucker</b> ADDRESS <b>Baltimore 12, Md.</b>						25a. REC'D BY REGISTRAR <b>NOV 17 '61</b> DATE			25b. REGISTRAR'S SIGNATURE <b>Charles S. Kraus</b>		

(M)

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Handwritten signature or initials, possibly "H. A. B. B. B."

Handwritten text at the bottom of the page, possibly a date or reference number.



1  
FOR STATE  
HEALTH DEPT.

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

12265  
MAYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MAYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 12251

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baynesville</u>		c. LENGTH OF STAY IN TB		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <u>Baynesville</u>		d. STREET ADDRESS <u>8201 Loch Raven Blvd.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>8201 Loch Raven Blvd.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Margaret Elizabeth Coffey</u>				4. DATE OF DEATH Month Day Year <u>Nov. 12 1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 14, 1890</u>	
9. AGE (In years last birthday) <u>71</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Emmett Martin</u>				14. MOTHER'S MAIDEN NAME <u>Mamie Daugherty</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Address <u>William F. Coffey 9404 Fullerdale Ave.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (b) } (a), stating the underlying cause last. (c) DUE TO <u>Sudden</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Charles F. O'Donnell</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Charles F. O'Donnell</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
				Address (Street, city, town, or county) <u>11/13/61</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>11/15/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral</u>		22d. LOCATION (City, town, or country) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc. 5305 Harford Rd.</u>				24a. REC'D BY REGISTRAR <u>NOV 14 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Charles L. Hume</u>	

MEDICAL CERTIFICATION

1881 MEDICAL EXAMINER'S CERTIFICATE OF DEATH



11/17/11

1  
FOR STATE  
HEALTH DEPT

TO DEED BY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE 12</b> c. LENGTH OF STAY IN 1b <b>8 YRS.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>6606 RAVEN HILL RD</b>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>BALTIMORE</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE 12</b> d. STREET ADDRESS <b>16606 RAVEN HILL RD</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ESTHER E. COHEN</b>		4. DATE OF DEATH <b>Nov. 26 1961</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-2-10</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>MD.</b>
13. FATHER'S NAME <b>John H. HOFFMAN</b>		14. MOTHER'S MAIDEN NAME <b>Rachel Ellen Barnes</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>UNK</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>LEONARD COHEN 6606 RAVEN HILL RD</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>1 MIN.</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>William A. Pillsbury</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>WILLIAM A. PILLSBURY</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <b>TIMOTHY M. MCDONALD</b>		DATE SIGNED <b>11-26-61</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>11/29/61</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>London Park Cem.</b>		22d. LOCATION (City, town, or country) (State) <b>Balto., Md.</b>	
23. FUNERAL DIRECTOR <b>John Burns' Sons, Towson, Md.</b>		24a. REC'D BY REGISTRAR <b>DEC 1 '61</b>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Krause</b>	

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Pages 3 and 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>—</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN <u>13 yr 1 mo 28 days</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		d. STREET ADDRESS <u>1714 North Wolfe Street</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>SPRING GROVE STATE HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Marie A. Colleran</u>				<b>4. DATE OF DEATH</b> Month <u>November</u> Day <u>6</u> Year <u>1961</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 20, 1894</u>		9. AGE (In years last birthday) <u>67</u> yrs.	IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u>	IF UNDER 24 HRS. Hours <u>—</u> Min. <u>—</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Martin Colleran</u>				14. MOTHER'S MAIDEN NAME <u>Sara Collahan</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal pneumonia</u> <u>355X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Senile brain disease</u> (a), stating the underlying cause last. DUE TO (c) <u>—</u>							INTERVAL BETWEEN ONSET AND DEATH <u>—</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u>—</u> a.m. <u>—</u> p.m. <u>19</u>		20d. INJURY OCCURRED While et work <input type="checkbox"/> Not While et work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <u>He</u> (this hospital) attended the deceased from <u>June 8, 1961</u> to <u>Nov. 6, 1961</u> , that (I) (we) last saw the deceased alive on <u>Nov. 6, 1961</u> , and that death occurred at <u>8:25</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Stella Wachslar, M.D.</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>11-6-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Stella Wachslar, M. D.</u>				22d. ADDRESS <u>SPRING GROVE STATE HOSPITAL</u> <u>Catonsville 28, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>11/8/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>NEW CATHEDRAL</u>		23d. LOCATION (City, town or county) (State) <u>BALTO. M.D.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>WITZKE F. DIR. 4101 EDMONDSON AVE</u>				25a. REC'D BY REGISTRAR <u>NOV 8 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Carlton S. Trane</u>	

15303

15303

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WITNESSES FOR THE EXHIBITION OF THE  
1/2-1/2 NEW ORLEANS  
JAN 8 1901



FOR STATE  
HEALTH DEPT.

TO DISTRIBUTE: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 9/60

<div>12-13-61, ams</div> <div>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>12268 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 12254</div>											
1. PLACE OF DEATH e. COUNTY <b>Baltimore</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>				c. LENGTH OF STAY IN 1b <b>79 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>				d. STREET ADDRESS <b>1118 East Belvedere</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Veterans Administration Hospital</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>CLARENCE W. CRABSON</b>						4. DATE OF DEATH Month <b>November</b> Day <b>19</b> Year <b>1961</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>August 21, 1894</b>		9. AGE (In years last birthday) <b>67</b> yrs.		IF UNDER 1 YEAR Months <b>6</b> Days <b>19</b> Hours <b>19</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Plasterer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>				11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>			
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>				13. FATHER'S NAME <b>Charles T. Crabson</b>				14. MOTHER'S MAIDEN NAME <b>Lucia Belt</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>				16. SOCIAL SECURITY NO. <b>217-05-1594</b>				17. INFORMANT <b>Clinical Records, VAH, Baltimore 18, Maryland</b> <b>FORT HOWARD DIVISION</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>904.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <b>FRACTURED HIP, RIGHT</b> (c) <b>PYELONEPHRITIS</b>										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>CHRONIC MYOCARDITIS</b>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fell at home</b>							
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>home</b>		20f. (City or town) <b>Balto.</b>		(County) (State) <b>- Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> . CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>											
ACTUAL SIGNATURE <b>MELVIN B. DAVIS, M.D.</b>						DATE SIGNED <b>11/20/61</b>					
EXAMINER'S NAME (Type) <b>MELVIN B. DAVIS, M.D.</b>						Address (Street, city, town, or county)					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>Nov. 24, 1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cemetery</b>				22d. LOCATION (City, town, or country) (State) <b>BALTIMORE COUNTY, MARYLAND</b>	
23. FUNERAL DIRECTOR ADDRESS <b>Burgee Funeral Home</b> <b>Horace F. Burgee, 3631 Falls Road, Balto.Md.</b>						24a. REC'D BY REGISTRAR <b>DATE NOV 22 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

MEDICAL CERTIFICATION



\* \* \*

5201 1-15-44 557-162

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

12269

12255

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Baltimore</b> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b> 98 Days c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Veterans Administration Hospital</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> 26 d. STREET ADDRESS <b>1617 Cypress Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) <b>HARRY J. CROGHAN</b> First Middle Last <b>4. DATE OF DEATH</b> <b>November 6 19 61</b> Month Day Year				<b>5. SEX</b> <b>Male</b> <b>6. COLOR OR RACE</b> <b>White</b> <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					
<b>8. DATE OF BIRTH</b> <b>August 18, 1892</b> <b>9. AGE</b> (In years last birthday) <b>69 yrs.</b> IF UNDER 1 YEAR: Months Days Hours Min.				<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Police Officer</b> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Police - Retired</b> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Baltimore, Maryland</b> <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U. S. A.</b>					
<b>13. FATHER'S NAME</b> <b>Peter Croghan</b> <b>14. MOTHER'S MAIDEN NAME</b> <b>Mary E. Chambers</b>				<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>Yes WW I</b> <b>16. SOCIAL SECURITY NO.</b> <b>WW I</b> <b>17. INFORMANT</b> <b>Clinical Records, VAH, Baltimore 18, Maryland</b> <b>Address</b> <b>Fort Howard Division</b>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOGENIC CARCINOMA, LUNG, WITH METASTASIS TO BRAIN</b> DUE TO (b) <b>ARTERIOSCLEROSIS, GENERALIZED</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b> <b>UNKNOWN</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>SENILE EMPHYSEMA</b>								<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of Item 18.)				<b>20c. TIME OF INJURY</b> Month, Day, Year Hour e.m. p.m. <b>19</b>	
<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)				<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify</b> that <del>he</del> (this hospital) attended the deceased from <b>July 31 5:35 1961</b> , to <b>November 6 1961</b> , that <del>he</del> (we) last saw the deceased alive on <b>November 6 1961</b> , and that death occurred at <b>A.M.</b> , from the causes and on the date stated above.								<b>22b. DATE SIGNED</b> <b>11/6/61</b>	
<b>22a. SIGNATURE</b> <i>Thomas F. Crahan</i>				<b>ATTENDING PHYS.</b> <input type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input checked="" type="checkbox"/>				<b>22d. ADDRESS</b> <b>VAH, BALTO. 18 MD, FT. HOWARD DIVISION</b>	
<b>22c. PHYSICIAN'S NAME (Type)</b> <b>THOMAS F. CRAHAN, M.D.</b>				<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>				<b>23b. DATE THEREOF</b> <b>Nov. 10, 1961</b>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Holy Cross Cemetery</b>				<b>23d. LOCATION</b> (City, town or county) (State) <b>Baltimore, Maryland (A. A. Co.)</b>				<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <i>George J. Gonce</i>	
<b>24. FUNERAL DIRECTOR'S ADDRESS</b> <b>George J. Gonce, 4001 Ritchie Highway, Balto. 25, MD.</b>				<b>25a. REC'D BY REGISTRAR</b> <b>NOV 13 '61</b>				<b>25b. REGISTRAR'S SIGNATURE</b> <i>Arthur L. Trump</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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SECTION EMPLOYMENT

George J. Jones, 4001 Ritchie Highway, Balto., Md.  
Serial Nov. 10, 1945 Holy Cross Cemetery  
THOMAS E. CHASE, M.D.  
VAN, BALTO., MD., THOMAS DIVISION

*Handwritten signature*

THOMAS E. CHASE, M.D.  
VAN, BALTO., MD., THOMAS DIVISION

November 6 1945  
November 6 1945

ANTHROPOLOGISTS, GENERALIST  
BRAIN  
BIOLOGISTS TO CARCERONA, JUNG, WITH NEARLY 20  
UNKNOWN

Yes

Peter Croghan

Police Officer

Police - Medical, Baltimore, Maryland

U. S. A.

White

August 10, 1945

HARRIS

J.

OBOGNA

November 6

61

Veterans Administration Hospital

1047 Cypress Street

35 days

Baltimore

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Baltimore

Baltimore

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# CERTIFICATE OF DEATH

Sol. Levinson & Bros. Inc. 6010 Reist Road

1888

CERTIFICATE OF DEATH

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

12271

12257

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>1726 E. Joppa Road</b>				d. STREET ADDRESS <b>1726 E. Joppa Road</b>			
3. NAME OF DECEASED (Type or print) <b>CHARLES HOCKING CROSS</b>				4. DATE OF DEATH <b>November 30, 1961</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 19, 1888</b>	
9. AGE (In years last birthday) <b>73</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter- retired</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Self employed</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Unknown James Robert Cross</b>				14. MOTHER'S MAIDEN NAME <b>Dorothea L. Smith</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give year or dates of service) <b>None</b>				16. SOCIAL SECURITY NO. <b>220-30-3761</b>			
17. INFORMANT <b>Kenneth Cross, 1726 E. Joppa Rd., Towson 4, Md.</b>				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <b>260X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <b>Cornary Occlusion</b> <b>Arterio-sclerosis</b> <b>Diabetes</b>				INTERVAL BETWEEN ONSET AND DEATH <b>6 days</b> <b>5 years</b> <b>10 years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1 July 1946</b> to <b>30 Nov 1961</b> , that (I) (we) last saw the deceased alive on <b>25 Nov 1961</b> , and that death occurred at <b>3 PM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Charles H. Treier</b> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>1 Dec 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>Charles H. Treier</b>				22d. ADDRESS <b>6701 York Rd. Balto 12 Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Dec. 4, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Zion Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Freeland, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>John Burns' Sons, Towson, Maryland</b>				25a. REC'D BY REGISTRAR <b>DEC 6 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Charles L. Kline</b>	



Belmore

Town

1750 E. 10th Ave

CHARLES HICKING CROSS  
X

White

June 19, 1968

Carpenter - retired

Maryland

Belmore Town, West Cross

2201-22-221

Belmore Town, West Cross, 1750 E. 10th Ave., Town 1, Md.

*Handwritten notes:*  
Belmore Town, West Cross  
2201-22-221  
June 19, 1968

*Handwritten notes:*  
Belmore Town, West Cross  
2201-22-221  
June 19, 1968

Belmore Town, West Cross, 1750 E. 10th Ave., Town 1, Md.

Belmore Town, West Cross, 1750 E. 10th Ave., Town 1, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

12272

12258

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b> c. LENGTH OF STAY IN 1b <b>28 Days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Veterans Administration Hospital</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>5523 Ashbourne Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <b>WILLIAM J. DAVIES</b>		<b>4. DATE OF DEATH</b> Month <b>November</b> Day <b>15</b> Year <b>1961</b>	
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>August 9, 1894</b>
<b>9. AGE</b> (In years last birthday) <b>67</b> yrs.		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Guard-chauffeur</b>	
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Philadelphia, Pennsylvania</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U. S. A.</b>	
<b>13. FATHER'S NAME</b> <b>Thomas Davies</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Mary Jane Gray</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>Yes</b> (If yes give war or dates of service) <b>WW I</b>		<b>16. SOCIAL SECURITY NO.</b> <b>136-01-5172</b>	
<b>17. INFORMANT</b> <b>Clinical Records, VAH, Baltimore 18, Maryland</b> <b>Fort Howard Division</b>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF ASCENDING COLON WITH METASTASES</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c)	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, notify medical examiner)		<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town) (County) (State)</b>
<b>21. I certify that</b> <b>18</b> (this hospital) attended the deceased from <b>October 18, 1961</b> to <b>November 15, 1961</b> , that <b>11</b> (we) last saw the deceased alive on <b>Nov. 15, 1961</b> , and that death occurred at <b>8:15 P.M.</b> from the causes and on the date stated above.			
<b>22a. SIGNATURE</b> <b>R. H. ROBERTSON, JR., M. D.</b>		<b>22b. DATE SIGNED</b> <b>11/16/61</b>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>R. H. ROBERTSON, JR., M. D.</b>		<b>22d. ADDRESS</b> <b>VAH, BALTIMORE 18, MD., FT. HOWARD DIVISION</b>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>11/20/61</b>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Baltimore National Cem.</b>		<b>23d. LOCATION</b> (City, town or county) (State) <b>Baltimore 28, Maryland</b>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Wm. Cook-Blight, Inc., 6009 Harford Rd., #14</b>		<b>25a. REC'D BY REGISTRAR</b> <b>NOV 20 1961</b>	
<b>25b. REGISTRAR'S SIGNATURE</b> <b>Charles S. Harris</b>			



Washington

John Brown

50 days

Baltimore

27

Veterans Administration Hospital

323 Ambrose Road

William

J.

DAVIS

November 15

21

Miss

August 9, 1934

27

General

U.S. Government

Washington, D.C.

Thomas Davis

Miss Jane Gray

Official Records, V&A, Baltimore 18, Maryland

133-01-2115

Yes

CAUTION: OF RECORDING GOLD WITH MEMORANDUM

WHICH

October 10, 1934

Nov. 13

V&A, BALTIMORE 18, D., P.T. HOWARD DIVISION

M. A. ROBINSON, JR., M. A.

Baltimore National Com.

Print

Mr. Cook-Bright, Inc., 5009 Harford Rd., Bt.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

12273

12259

<b>1. PLACE OF DEATH</b> e. COUNTY <u>Baltimore</u> f. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u> g. LENGTH OF STAY IN TB <u>6 days</u> h. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Veterans Administration Hospital</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore - 22</u> d. STREET ADDRESS <u>2907 Dunmurry Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>JAMES T. DAVIS</u>		<b>4. DATE OF DEATH</b> Month Day Year <u>November 19 19 61</u>	
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>March 2, 1893</u>
<b>9. AGE</b> (In years last birthday) <u>68</u> yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Laborer</u>	
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Statesville, N.C.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>Luther B. James</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Ella Johnston</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give year or dates of service) <u>Yes WW-1</u>		<b>16. SOCIAL SECURITY NO.</b> <u>213-09-4380</u>	
<b>17. INFORMANT</b> Address <u>Clinical Records VA Hospital</u> <u>Baltimore 18, Maryland - FORT HOWARD DIVISION</u>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHOPNEUMONIA AND PULMONARY EDEMA</u> DUE TO (b) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u> DUE TO (c) <u>CEREBRAL THROMBOSIS</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>1 DAY</u> <u>MANY YEARS</u> <u>RECENT</u>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o.m. p.m. <u>19</u>	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town)</b> (County) (State) <u>Baltimore</u>
<b>21. I certify that</b> <u>NO</u> (this hospital) attended the deceased from <u>Nov. 13, 1961</u> to <u>Nov. 19, 1961</u> that <u>NO</u> (we) last saw the deceased alive on <u>Nov. 19, 1961</u> , and that death occurred at <u>12:40 P.M.</u> from the causes and on the date stated above.			
<b>22a. SIGNATURE</b> <u>Ernest O. Brown</u> M.D.		<b>22b. DATE SIGNED</b> <u>11-19-61</u>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>Ernest O. Brown</u> M.D.		<b>22d. ADDRESS</b> <u>VAH Baltimore 18, Md - Fort Howard Div.</u>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>	<b>23b. DATE THEREOF</b> <u>11-22-61</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Baltimore National Cemetery</u>	<b>23d. LOCATION</b> (City, town or county) (State) <u>Baltimore, Maryland</u>
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>William Cook-Blight, Inc.</u>		<b>25a. REC'D BY REGISTRAR</b> <u>NOV 21 '61</u>	
<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kline</u>		ADDRESS <u>6009 Harford Road</u> <u>Baltimore 11, Md.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 22 hours after death.

VR A15 (4)  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

12274

12260

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b> c. LENGTH OF STAY IN 1b <b>9 Days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Veterans Administration Hospital</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, If Institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>1210 West Franklin Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <b>JOHN ----- DAVIS</b>		<b>4. DATE OF DEATH</b> Month Day Year <b>November 16 1961</b>			
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>Negro</b>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>August 16, 1891</b>		
<b>9. AGE</b> (In years last birthday) <b>70 yrs.</b>		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Laborer</b>			
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Harnett Co., N. Carolina</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U. S. A.</b>			
<b>13. FATHER'S NAME</b> <b>Henry Davis</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Susanna Smith</b>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW I</b>		<b>16. SOCIAL SECURITY NO.</b> <b>218-10-0828</b>			
<b>17. INFORMANT</b> <b>Clinical Records, VAH, Fort Howard Division</b>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>STAPHYLOCOCCUS PNEUMONIA, LEFT LUNG</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>MULTIPLE MYELOMA</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>491X XXXX</b>		INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b> <b>UNKNOWN</b>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of Injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>	<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town) (County) (State)</b>		
<b>21. I certify that</b> <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>November 7, 1961</b> , to <b>November 16, 1961</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>November 16, 1961</b> , and that death occurred at <b>3:15 PM</b> , from the causes and on the date stated above.					
<b>22a. SIGNATURE</b> <i>Sebastian Russo</i> <b>22c. PHYSICIAN'S NAME (Type)</b> <b>SEBASTIAN RUSSO, M.D.</b>		<b>22b. DATE SIGNED</b> <b>11/16/61</b> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> <b>22d. ADDRESS</b> <b>VAH, BALTIMORE 18, MARYLAND, FT. HOWARD DIV.</b>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>	<b>23b. DATE THEREOF</b> <b>11-20-61</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Baltimore National Cemetery Baltimore</b>	<b>23d. LOCATION</b> (City, town or county) (State) <b>28, Maryland</b>		
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Elroy O. Wilson, 1000 Brantley Ave., Balto.</b>		<b>25a. REC'D BY REGISTRAR</b> <b>NOV 20 '61</b> <b>25b. REGISTRAR'S SIGNATURE</b> <i>William S. Hume</i>			

VR A15 (4)  
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Belmont

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2 days

Belmont

Also with Franklin Street

Government Administration Building

JOHN

DAVIS

November 15

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August 10, 1951

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Import

Consolidation

Harris Co., N. Carolina

General Sales

Henry Davis

Clinical Research, VAMC, Fort Howard Division  
Baltimore, Md.

10-10-55

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WASHINGTON, D.C. 20540

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WASHINGTON, D.C. 20540

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November 10 61

November 1 61

November 20 61

WASHINGTON, D.C.

VAMC, BIRMINGHAM 18 WAREHOUSING, 21 BIRMINGHAM, ALA.

BIRMINGHAM NATIONAL CREDIT BUREAU, 20, BIRMINGHAM

ELSON, O. WILSON, 1000 BRADLEY AVE., BALTO. 11 MD.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 5, MARYLAND									
12275 CERTIFICATE OF DEATH 12261									
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>			c. LENGTH OF STAY IN 1b <b>1mth2dys</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b>			d. STREET ADDRESS <b>1515 Tiemon Drive</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>					a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>Grace</b>		First Middle Last		4. DATE OF DEATH <b>November 6 1961</b>		Month Day Year			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 2, 1899</b>		9. AGE (In years last birthday) <b>62 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife Seamstress</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Mens Clothing Factory</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Italy</b>		12. CITIZEN OF WHAT COUNTRY? <b>Italy</b>		
13. FATHER'S NAME <b>Jack Montalto</b>				14. MOTHER'S MAIDEN NAME <b>Agatha Buroco</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>unknown NO</b>		16. SOCIAL SECURITY NO. <b>215-03-7046</b>		17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Renal failure - anuria</b> DUE TO <b>Diabetes Mellitus</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerosis; old left hip fracture January 1961</b>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>slipped in snow</b>							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>Aug. 16 1961</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) <b>Glenburnie</b>		(County) <b>Maryland</b>	
21. I certify that (this hospital) attended the deceased from <b>Aug. 16 1961</b> to <b>Nov. 6 1961</b> , that (I) (we) last saw the deceased alive on <b>Nov. 6 1961</b> , and that death occurred at <b>2:15 P.M.</b> from the causes and on the date stated above.									
22a. SIGNATURE <b>STELLA Wachslar</b> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <b>SPRING GROVE STATE HOSPITAL</b>		22b. DATE SIGNED <b>11-6-61</b>			
22c. PHYSICIAN'S NAME (Type) <b>Stella Wachslar, M. D.</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/9/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cemetery</b>		23d. LOCATION (City, town or county) <b>Baltimore, Md.</b>		(State)	
24. FUNERAL DIRECTOR'S SIGNATURE <b>G. Vernon Lemmon</b>				ADDRESS <b>4611 Park Heights Ave. Balto.</b>		25a. REC'D BY REGISTRAR <b>NOV 8 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hanna</b>	

1938

1938

M

Seamstress Home Clothing Factory

NO

11/9/61 Holy Redeemer Cemetery Baltimore, Md.  
411 Park Heights Ave. Balto. Md.

## CERTIFICATE OF DEATH

Reg. Dist. No. 12262

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>—</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto City</u> 3V014	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Summit Nursing Home</u>		d. STREET ADDRESS <u>5955 Barton Hgts Ave</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Rosa (Rosing) DiFilippo</u>		4. DATE OF DEATH Month Day Year <u>Nov 19 1961</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1878</u> <u>May 31 1871</u>
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At home</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Italy</u>		12. CITIZEN OF WHAT COUNTRY? <u>Italy</u>	
13. FATHER'S NAME <u>unknown</u>		14. MOTHER'S MAIDEN NAME <u>Amelia</u> <u>unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>Philip J. DiFilippo 4006 Eldora Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>334X</u> DUE TO <u>Generalized Arterio Sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic Brain Syndrome</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Res.</u>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>11/18/61</u> to <u>11/19/61</u> , that I last saw the deceased alive on <u>11/18/61</u> , and that death occurred at <u>100 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. E. McGrath</u>		ADDRESS (Street, city or town, state) <u>1303 Frederick Rd</u> DATE SIGNED <u>11/19/61</u>	
PHYSICIAN'S NAME (Type) <u>W. E. McGrath</u>		<u>Catonsville 28md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11/22/61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer</u>	22d. LOCATION (City, town, or county) (State) <u>Balto MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>L. J. Ruck</u> ADDRESS <u>5305 Hanford Rd</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 21 '61</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thoma</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF LITIGATION

12551



Blank form with horizontal lines for text entry.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
M 9/60

1

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
12277 CERTIFICATE OF DEATH 12263

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Talbot</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Owings Mills</b>		c. LENGTH OF STAY IN 1b <b>8 years</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Rosewood State Training School</b>		d. STREET ADDRESS <b>St. Michaels</b> <b>Chew Avenue</b>	
<b>3. NAME OF DECEASED</b> (Type or print) <b>Beverly Jean Dornton</b>		<b>4. DATE OF DEATH</b> Month <b>11</b> Day <b>6</b> Year <b>19 61</b>	
<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>3/18/50</b>
<b>9. AGE</b> (In years last birthday) <b>11 yrs.</b>		<b>IF UNDER 1 YEAR</b> Months <b>11</b> Days <b>6</b> Hours <b>19</b> Min. <b>61</b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>dependent</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>none</b>	
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Easton, Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>Clyde Warner Dornton</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Jean Beverly Kelmon</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>no</b>		<b>16. SOCIAL SECURITY NO.</b> <b>----</b>	
<b>17. INFORMANT</b> <b>Rosewood Records, Owings Mills, Md.</b>		<b>Address</b>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Aspiration pneumonitis</b>			
DUE TO (b) <b>Respiratory infection (allergy and emphysema)</b>			
DUE TO (c) <b>Atonic diplegia congenital (since birth)</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>6/18/53</b> , <b>19</b> , to <b>11/6</b> , <b>1961</b> , that (I) (we) last saw the deceased alive on <b>11/6</b> , <b>19</b> , <b>61</b> , and that death occurred at <b>4:20 a.m.</b> on the date stated above.			
<b>22a. SIGNATURE</b> <b>Harry G. Butler</b>		<b>22b. DATE SIGNED</b> <b>11/6/61</b>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>Harry G. Butler, M.D.</b>		<b>22d. ADDRESS</b> <b>Rosewood State Training School, Owings Mills</b>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>Nov-8-61</b>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Chert Cemetery</b>		<b>23d. LOCATION</b> (City, town or county) (State) <b>St. Michaels. Md</b>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Hamilton Harrison</b>		<b>25a. REC'D BY REGISTRAR</b> <b>NOV 9 '61</b>	
<b>ADDRESS</b> <b>St. Michaels, Md</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Kraus</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
15M 9/59

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12278  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

12264

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sparks rural</b>		c. LENGTH OF STAY IN 1b <b>10 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Yeoho Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Peter Rob Drummond</b>		4. DATE OF DEATH Month Day Year <b>11-15- 19 61</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-9-1897</b>
9. AGE (In years last birthday) <b>64</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during last of working life, even if retired) <b>Metallurgical Eng.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Smelting Co.</b>	
11. BIRTHPLACE (State or foreign country) <b>Scotland, England</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Wm. Drummond</b>		14. MOTHER'S MAIDEN NAME <b>Mary Poole</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>219-12-9738</b>	
17. INFORMANT <b>Ruth J. Drummond,</b>		Address <b>Sparks, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> <b>592X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) <b>Chronic nephritis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes Mellitus; Recent respiratory illness</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b> <b>42 years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>May 1947</b> to <b>15 Nov. 1961</b> , that (I) (we) lost saw the deceased alive on <b>15 Nov 1961</b> , and that death occurred at <b>10:30 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>J. Douglas Lockard</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>J. DOUGLAS LOCKARD, M.D.</b>		22d. ADDRESS <b>802 Cathedral Street, Balto., 1, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11-17-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Grove</b>		23d. LOCATION (City, town, or county) (State) <b>Parkton, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Brooks Funeral Service, Towson 4, Md.</b>		25. REC'D BY REGISTRAR DATE <b>NOV 20 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles E. Kline</b>			

1994

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 Film G301 11/29/61 iwk

CERTIFICATE OF DEATH

Items 8 & 9 Film G302 12/4/61 iwk

Reg. Dist. No. 12265

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> c. LENGTH OF STAY IN 1b <u>Baltimore</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>House in Pines</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>5727 Clover Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ABRAHAM</u> First <u>DUKEHART</u> Middle <u>DUKEHART</u> Last 4. DATE OF DEATH <u>11-23-1961</u> Month <u>11</u> Day <u>23</u> Year <u>1961</u>		9. AGE (In years last birthday) <u>86</u> yrs. IF UNDER 1 YEAR: Months <u>8</u> Days <u>7</u> Hours <u>7</u> Min. IF UNDER 24 HRS.	
5. SEX <u>male</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>12/12/1874</u> 9. AGE (In years last birthday) <u>86</u> yrs. IF UNDER 1 YEAR: Months <u>8</u> Days <u>7</u> Hours <u>7</u> Min. IF UNDER 24 HRS.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Mens Furnishing</u> 11. BIRTHPLACE (State or foreign country) <u>Russia</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Zalman</u> 14. MOTHER'S MAIDEN NAME <u>Not Known</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>Leon Dukehart - Bause</u> 17. INFORMANT <u>Leon Dukehart - Bause</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO <u>Arteriosclerotic Cardio-Vascular Disease</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO <u></u> (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u> <u>15 yr</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <u>11-18</u> , 19 <u>61</u> , to <u>11-23</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>11-22</u> , 19 <u>61</u> , and that death occurred at <u>8:45 P.</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>6209 Frederick Ave Baltimore, Md</u> DATE SIGNED <u>11/24/61</u>	
ACTUAL SIGNATURE <u>Wilmer K. Gallagher</u> M.D. <u>6209 Frederick Ave Baltimore, Md</u> PHYSICIAN'S NAME (Type) <u>Wilmer K. Gallagher</u> <u>Baltimore - 28, Md</u>		22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>11-26-61</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Rosedale</u> 22d. LOCATION (City, town, or county) (State) <u>Balto Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Lewis Mc</u> ADDRESS <u>2100 E. E. Place</u> 24a. REC'D BY REGISTRAR <u>NOV 27 '61</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraw</u>			

CERTIFICATE OF DEATH

1923

(M)

Name of Deceased		Age		Sex		Race		Date of Death		Place of Death	
John J. Smith		45		Male		White		July 15, 1923		Boston, Mass.	
Cause of Death		Disease		Duration		Occupation		Marital Status		Signature of Physician	
Heart Disease		Myocardial Infarction		3 weeks		Carpenter		Married		J. J. Smith	
Place of Burial		Date of Burial		Signature of Undertaker		Signature of Registrar		Signature of Witness		Signature of Deceased	
Catholic Cemetery		July 18, 1923		J. J. Smith		J. J. Smith		J. J. Smith		J. J. Smith	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12280

## CERTIFICATE OF DEATH

12266

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b> c. LENGTH OF STAY IN 1b <b>5 Days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Veterans Administration Hospital</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>1639 Fleet Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <b>ADAM DUMBROWSKI</b>				<b>4. DATE OF DEATH</b> Month Day Year <b>November 13 19 61</b>							
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>September 25, 1887 74</b>		<b>9. AGE</b> (In years last birthday) yrs. <b>74</b> IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Shoe Repairman</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Shoe Shop</b>				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Poland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U. S. A.</b>	
<b>13. FATHER'S NAME</b> <b>Adam Dumbrowski</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Josephine Staiak</b>				<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW I</b>			
<b>16. SOCIAL SECURITY NO.</b>				<b>17. INFORMANT</b> Address <b>Clinical Records, VAH, Baltimore 18, Maryland</b> <b>FORT HOWARD DIVISION</b>				<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PULMONARY CONGESTION AND EDEMA</b> DUE TO <b>ARTERIOSCLEROTIC HEART DISEASE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>NEPHROSCLEROSIS, ARTERIOSCLEROTIC</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Benign Prostatic Hypertrophy</b>			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> <b>Baltimore</b>		<b>(County)</b> <b>Baltimore</b>		<b>(State)</b> <b>Maryland</b>	
<b>21. I certify</b> that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>November 8 19 61</b> to <b>November 13 19 61</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>November 13 19 61</b> , and that death occurred at <b>7:30 A.M.</b> , from the causes and on the date stated above.											
<b>22a. SIGNATURE</b> <i>Thomas F. Crahan</i> <b>THOMAS F. CRAHAN, M.D.</b>				<b>22b. DATE SIGNED</b> <b>11/13/61</b>				<b>22c. PHYSICIAN'S NAME</b> (Type) <b>THOMAS F. CRAHAN, M.D.</b>			
<b>22d. ADDRESS</b> <b>VAH, Baltimore 18, Maryland, Ft. Howard Div.</b>				<b>22e. ATTENDING PHYS.</b> <input type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input checked="" type="checkbox"/>				<b>22f. ADDRESS</b>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>				<b>23b. DATE THEREOF</b> <b>11-5-61</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Baltimore National Cem.</b>		<b>23d. LOCATION</b> (City, town or county) <b>Baltimore</b>		<b>(State)</b> <b>28, Maryland</b>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Wm. Cook-Blight, Inc., 6009 Harford Rd., Baltol 4, Md.</b>				<b>25a. REC'D BY REGISTRAR</b> <b>NOV 15 '61</b>				<b>25b. REGISTRAR'S SIGNATURE</b> <i>Arthur S. Kraus</i>			

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U.S. DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
12281 Item 13 Film G300 11/17/61 iwk 12267											
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Halethorpe</b>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore (Halethorpe)</b>					
c. LENGTH OF STAY IN 1b						d. STREET ADDRESS <b>5712 Second Avenue</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>5712 Second Avenue</b>						a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Clinton Base Eck</b>						4. DATE OF DEATH <b>Nov. 9, 1961</b>					
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12/10/1898</b>		9. AGE (In years last birthday) <b>62 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>supervisor</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Western Electric Md.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
13. FATHER'S NAME <b>Unknown Charles H. Eck</b>						14. MOTHER'S MAIDEN NAME <b>Sally Shaffer</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>no</b>						16. SOCIAL SECURITY NO. <b>no</b>					
17. INFORMANT (wife) <b>Mrs. Ethel O. Eck</b>						Address <b>5712 Second Ave. #27</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Coronary embolism</b> (c) <b>Second episode - embolism</b>										INTERVAL BETWEEN ONSET AND DEATH <b>5 + 4.5</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>1961</b> to <b>Nov 9, 1961</b> , that (I) (we) last saw the deceased alive on <b>Nov 9, 1961</b> , and that death occurred at <b>7:30</b> M, from the causes and on the date stated above.											
22a. SIGNATURE <b>Frederic Beitler</b>						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <b>Frederic Beitler, M. D.</b>						22d. ADDRESS <b>1014 Francis Avenue #27</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>11/11/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Cemetery</b>				23d. LOCATION (City, town or county) (State) <b>Elkridge, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Howard H. Hubbard</b>						ADDRESS <b>4107 Wilkens Avenue</b>		25a. REC'D BY REGISTRAR <b>NOV 13 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

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Western Electric. No.

A. B. V.

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Daily, 1972, 1152

(S.I.W.)

On

Mr. Robert C. Holt 2112 Second Ave.

FredERIC BOLTER, N. D.

JOHN L. BROWN

Howard N. Hubbard 4107 Wilkins Avenue

Washburn & Glen (1973)

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**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

12282

12268

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cockeysville</i>		c. LENGTH OF STAY IN 1b <i>4 yrs.</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i>		b. COUNTY <i>Baltimore</i>			
3. NAME OF DECEASED (Type or print) First <i>Freda</i> Middle <i>Ella</i> Last <i>Eidman</i>		4. DATE OF DEATH Month <i>November</i> Day <i>27</i> Year <i>1961</i>		5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. B. DATE OF BIRTH <i>July 8, 1882</i>		9. AGE (In years last birthday) <i>79</i> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>			
12. CITIZEN OF WHAT COUNTRY? <i>USA.</i>		13. FATHER'S NAME <i>Jacob Henry Eypler</i>		14. MOTHER'S MAIDEN NAME <i>Fredericka Contes</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>—</i>			
17. INFORMANT <i>McMasonic Home Records.</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Generalized arteriosclerosis</i> <i>450.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Fracture - intertrochanteric, Rt femur, comminuted. Aug 6</i>		INTERVAL BETWEEN ONSET AND DEATH <i>years.</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <i>Oct 1961</i> to <i>Nov 1961</i> , that (I) (we) last saw the deceased alive on <i>Nov 27</i> 1961, and that death occurred at <i>11:25 A</i> M, from the causes and on the date stated above.			
22a. SIGNATURE <i>Elizabeth B. Sherrill</i>		22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) <i>Elizabeth B. Sherrill, MD</i>		22d. ADDRESS <i>Cockeysville Md.</i>		22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE THEREOF <i>11-30-61</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Loudon Park Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>Baltimore</i>		24. FUNERAL DIRECTOR'S SIGNATURE <i>Wm. Cook, Inc., 1217 St. Paul Street, Zone 2</i>			
25a. REC'D BY REGISTRAR <i>NOV 29 '61</i>		25b. REGISTRAR'S SIGNATURE <i>Charles E. Kline</i>		25c. DATE		25d. TIME		25e. SIGNATURE			

OK-BY DR. CHAS. F. O'CONNELL - BALTO. COUNTY MEDICAL EXAMINER

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) d. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural- Randallstown</b>		c. LENGTH OF STAY IN 1b <b>9 years</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural- Randallstown</b>		d. STREET ADDRESS <b>Box 244, Liberty Road</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Box 244, Liberty Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Mr. Paul</b> Middle <b>Elder</b> Last <b>Elder</b>		4. DATE OF DEATH Month <b>November</b> Day <b>5,</b> Year <b>19 61</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 19, 1885</b>
9. AGE (In years last birthday) <b>76</b> yrs.		IF UNDER 1 YEAR Months <b>76</b> Days <b>76</b> Hours <b>76</b> Min. <b>76</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Specialist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Md. Drydock</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Henry C. Elder</b>		14. MOTHER'S MAIDEN NAME <b>Catherine McCarren</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-05-9105</b>	
17. INFORMANT <b>Mrs. Maude E. Dittus, Box 244, Liberty Road, Randallstown, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>CORONARY INSUFFICIENCY</b> DUE TO (c) <b>ARTERIO SCLEROTIC CARDIO VASCULAR DISEASE 10 yrs</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 YRS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Romulus V. Houck, Jr.</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Romulus V. Houck, Jr.</b>		22d. ADDRESS <b>Liberty Road, Eldersburg</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/8/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Loring Byers</b>		25a. REC'D BY REGISTRAR <b>NOV 9 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>			

SPSS<sup>®</sup>

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

1  
FOR STATE  
HEALTH DEPT.

MEDICAL CERTIFICATION

ACTUAL SIGNATURE *William A. Pillsbury*  
EXAMINER'S NAME (Type) *William A. Pillsbury*

22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>12-1-61</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Auburn</b>	22d. LOCATION (City, town, or country) (State) <b>Baltimore, Maryland</b>
23. FUNERAL DIRECTOR <b>Charles R. Law</b>		ADDRESS <b>802 Madison Ave., Balto., Md.</b>	
24a. REC'D BY REGISTRAR <b>DEC 4 '61</b>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. P...</i>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRO-VASCULAR ACCIDENT</b> <b>422.1</b> DUE TO <b>ARTEROSCLEROTIC CARDIOVASCULAR DISEASE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH <b>1 MIN.</b> <b>1 YR</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
Address (Street, city, town, or county) <b>11-17-61</b>			

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>COCKEYSVILLE</b> c. LENGTH OF STAY IN 1b <b>2 mos.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MASONIC HOME</b>		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>BALTIMORE</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X COCKEYSVILLE</b> d. STREET ADDRESS <b>1 MASONIC HOME</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>SEAMAN</b> First Middle Last <b>— ELDRIDGE</b>		4. DATE OF DEATH Month Day Year <b>NOV. 17 1961</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>C</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-3-10</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HELPER</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Birmingham, Ala.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>212-12-4091</b>	
17. INFORMANT		Address	

12284  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 12270

4851

2000

1924-25

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

12285

STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 8 Film 6300

12271

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Sparrows Point</b> c. LENGTH OF STAY IN 1b <b>Bethlehem Steel Co. Dispensary</b>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore-14</b> d. STREET ADDRESS <b>2620 Burridge Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Joseph N. Ellardo</b>		4. DATE OF DEATH <b>Nov. 3, 1961</b>		5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11-26-1912</b>		9. AGE (In years last birthday) <b>48</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Foreman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Steel</b>		11. BIRTHPLACE (State or foreign country) <b>Italy</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Harry Ellardo</b>		14. MOTHER'S MAIDEN NAME <b>Not known</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>Doris E. Ellardo</b>	
17. INFORMANT <b>same</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary Occlusion</b> Conditions, if any, which gave rise to immediate cause (b) <b>420.1</b> DUE TO <b>Coronary Occlusion</b> (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>None</b>	
20e. (City or town) <b>Baltimore</b>		20f. (County) <b>Baltimore</b>		20g. (State) <b>Md.</b>		20h. (Country) <b>USA</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>M.B. Davis</b>		M.D. <b>M. B. Davis, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>M. B. Davis, M.D.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>11/3/61</b>		Address (Street, city, town, or county)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>11-7-61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Moreland Mem. Park</b>		22d. LOCATION (City, town, or country) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR <b>Leonard J. Ruck</b>		ADDRESS <b>5305 Harford Road #14</b>		24a. REC'D BY REGISTRAR <b>NOV 7 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

MASSACHUSETTS DEPARTMENT OF HEALTH  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH  
1938

1938

(M)

11-11-1938

George W. Brown

Wife

Wife

George W. Brown

11-11-1938



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## 12286 CERTIFICATE OF DEATH

12272

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> <span style="float: right;">c. LENGTH OF STAY IN 1b</span> <u>2yr4mth2dys</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SPRING GROVE STATE HOSPITAL</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution residence before admission) e. STATE <u>Maryland</u> <span style="float: right;">b. COUNTY</span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <span style="float: right;">3v01-4</span> d. STREET ADDRESS <u>3535 Horton Avenue</u> • IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
<b>3. NAME OF DECEASED</b> (Type or print) <u>Ethel</u> <span style="float: right;">First</span> <u>Feehley</u> <span style="float: right;">Middle</span>		<b>4. DATE OF DEATH</b> Month <u>November</u> Day <u>28</u> Year <u>1961</u>		<b>5. SEX</b> <u>female</u>		<b>6. COLOR OR RACE</b> <u>white</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>Dec. 27, 1899</u> <span style="float: right;">61 yrs.</span>		<b>9. AGE</b> (In years last birthday) <u>61</u> <span style="float: right;">IF UNDER 1 YEAR</span> Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>housewife</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>unknown</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U. S. A.</u>		<b>13. FATHER'S NAME</b> <u>unknown</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>unknown</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>unknown</u> <span style="float: right;">(If yes give year or dates of service)</span>				<b>16. SOCIAL SECURITY NO.</b> <u>unknown</u>				<b>17. INFORMANT</b> <u>Records: SPRING GROVE STATE HOSPITAL</u> <span style="float: right;">Address</span>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (b) <u>Generalized arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____										<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)									
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>			
<b>21. I certify that</b> (If this hospital attended the deceased from <u>July 22, 1959</u> to <u>Nov. 28, 1961</u> that (I) (we) last saw the deceased alive on <u>Nov. 28, 1961</u> , and that death occurred at <u>8:45</u> M., from the causes and on the date stated above.													
<b>22a. SIGNATURE</b> <u>Stella Wachslar</u> <span style="float: right;">M.D.</span>						<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/> <span style="float: right;">22b. DATE SIGNED</span> <u>11-28-61</u>		<b>22c. PHYSICIAN'S NAME</b> (Type) <u>Stella Wachslar, M. D.</u>		<b>22d. ADDRESS</b> <u>SPRING GROVE STATE HOSPITAL</u> <u>Catonsville 28, Maryland</u> <span style="float: right;">(State)</span>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>12/1/61</u>		<b>23b. DATE THEREOF</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>GLENN LAUREN</u>		<b>23d. LOCATION</b> (City, town, or county) <u>Balt.</u>		<b>(State)</b>		<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Mc Cully F. Hous.</u> <span style="float: right;">ADDRESS</span> <u>130 E Fort Ave 30, City.</u>			
<b>25a. REC'D BY REGISTRAR</b> <u>NOV 29 '61</u>				<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Hines</u>									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
 15M 9/60

15375

15375

(M)

(I)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12287

## CERTIFICATE OF DEATH

Reg. Dist. No. 12273

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>7906 Milbury Road</b>				d. STREET ADDRESS <b>7906 Milbury Road</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>BENJAMIN ( BENNY) FEIT</b>			4. DATE OF DEATH Month Day Year <b>November 13, 1961</b>				
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 26, 1906</b>		9. AGE (In years last birthday) <b>55</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Proprietor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Drapery Business</b>		11. BIRTHPLACE (State or foreign country) <b>Austria</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Isaac Feit</b>				14. MOTHER'S MAIDEN NAME <b>Mollie ?</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes W W II</b>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Mrs. Rebecca Feit- 7906 Milbury Road</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart failure</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary sclerosis-Heart Disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <b>6 years</b>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1954</b> to <b>1961</b> , that I last saw the deceased alive on <b>1961 9</b> , and that death occurred at <b>3 A M</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>1010 St. Paul St.</b> DATE SIGNED ACTUAL SIGNATURE <b>Leonard C. Alman</b> M.D. PHYSICIAN'S NAME (Type) <b>Leonard C. Alman</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov 14/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Agudas Achim Anshe Sfard</b>		22d. LOCATION (City, town, or county) (State) <b>Rosedale, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Sol. Levinson &amp; Bros. Inc. 6010 Reist Road</b>				24a. REC'D BY REGISTRAR <b>NOV 17 1961</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	



1  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12288

12274

1. PLACE OF DEATH a. COUNTY <b>BALTO.</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>BALTO</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>TOWSON</b>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>TOWSON</b>			
c. LENGTH OF STAY IN life <b>LIFE</b>				d. STREET ADDRESS <b>385 ENDWOOD LANE</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>385 ENDWOOD LANE</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>JANET D. FERGUSON</b>				4. DATE OF DEATH <b>11/13/61</b>			
5. SEX <b>F</b>		6. COLOR OR RACE <b>NEGRO</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8/26/61</b>	
9. AGE (In years last birthday) <b>2</b> yrs.		10. IF UNDER 1 YEAR Months <b>2</b> Days <b>18</b>		11. IF UNDER 24 HRS. Hours <b>18</b> Min.		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>			
11. BIRTHPLACE (State or foreign country) <b>MD.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>			
13. FATHER'S NAME <b>CALVIN FERGUSON</b>				14. MOTHER'S MAIDEN NAME <b>BERTHA JOHNSON</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>				16. SOCIAL SECURITY NO. <b>NONE</b>			
17. INFORMANT <b>CALVIN FERGUSON - 385 ENDWOOD LANE</b>				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>475X</b> DUE TO <b>Acute Upper Respiratory Infection</b> Conditions, if any, which gave rise to immediate cause (b) <b>Sudden</b> (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Charles F. O'Donnell</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Charles F. O'Donnell</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>11/20/61</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>mt. cumber</b>				22d. LOCATION (City, town, or country) (State) <b>Balto. Md.</b>			
23. FUNERAL DIRECTOR <b>Wm. J. Chatterbox - 1701 77th Avenue St. Balto. Md.</b>				24a. REC'D BY REGISTRAR <b>NOV 20 '61</b>			
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed (filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12289

## CERTIFICATE OF DEATH

12275

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>North Point</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>North Point</u>	
c. LENGTH OF STAY IN 1b		d. STREET ADDRESS <u>17606 Cedar Rd</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7606 Cedar Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mary Ann Fitzpatrick</u>		4. DATE OF DEATH Month Day Year <u>11 18 19 61</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-24-1877</u>
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Monkton Md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Wm H Colwell</u>		14. MOTHER'S MAIDEN NAME <u>Lucinda Gallion</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRO-VASCULAR ACCIDENT</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>GENERALIZED ARTERIO-SCLEROSIS</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>1-2 HOURS</u> <u>SEVERAL YEARS</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>AUGUST 1961</u> to <u>NOV. 18, 1961</u> , that (I) (we) last saw the deceased alive on <u>NOV. 12 1961</u> , and that death occurred at <u>1 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Barnett Berman, M.D.</u> M.D.		22b. DATE SIGNED <u>11/20/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>BARNETT BERMAN, M.D.</u>		22d. ADDRESS <u>714 PARK AVE., 1, BALTO. MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>11/27/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer</u>	23d. LOCATION (City, town or county) (State) <u>Balto Md</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>L. J. Ruck Inc 5305 Haverford Rd</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 22 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>William S. Hanna</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>Catonsville</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> <b>Gorsuch Ave. Balto. Md.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Caton Ridge Nursing Home, 329 Harlem Lane</b>		d. STREET ADDRESS <b>Gorsuch Ave.</b>	
3. NAME OF DECEASED (Type or print) <b>Frederick R. Fleckenstein</b>		4. DATE OF DEATH <b>Nov. 25, 1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 19, 1882</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Watch Repairer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Watch</b>	11. BIRTHPLACE (State or foreign country) <b>Balto. Md.</b>
13. FATHER'S NAME <b>August Fleckenstein</b>		14. MOTHER'S MAIDEN NAME <b>Barbara Fleckenstein</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>---</b>		16. SOCIAL SECURITY NO. <b>219-30-5163</b>	17. INFORMANT <b>Wm. Fleckenstein, 4810 Aberdeen Ave.</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac failure &amp; pneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arterio sclerosis C-V-D</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>48 hrs</b> <b>unknown</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Nov 18</b> 19 <b>61</b> , to <b>Nov 25</b> 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>Nov 20</b> 19 <b>61</b> , and that death occurred at <b>1:30</b> AM, from the causes and on the date stated above.			
22a. SIGNATURE <b>Cliff Ratliff, Jr.</b>		22b. DATE SIGNED <b>11/27/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>CLIFF RATLIFF, JR.</b>		22d. ADDRESS <b>4605 EDMONDSON AVE.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Nov. 28, 1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Cem.</b>	23d. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Philip Herwigsons</b>		ADDRESS <b>2024 Orleans St. 31</b>	25a. REC'D BY REGISTRAR <b>NOV 29 '61</b>
			25b. REGISTRAR'S SIGNATURE <b>Arthur S. Evans</b>

1957

CERTIFICATE OF DEATH

1957

M

1. Name of deceased: [illegible]  
2. Sex: [illegible]  
3. Age: [illegible]  
4. Date of birth: [illegible]  
5. Date of death: [illegible]  
6. Place of death: [illegible]  
7. Cause of death: [illegible]  
8. Signature of physician: [illegible]  
9. Signature of registrar: [illegible]  
10. Date of registration: [illegible]

11. Name of informant: [illegible]  
12. Address of informant: [illegible]  
13. Signature of informant: [illegible]  
14. Date of completion: [illegible]  
15. Registrar's signature: [illegible]  
16. Registrar's name: [illegible]  
17. Registrar's title: [illegible]  
18. Registrar's address: [illegible]  
19. Registrar's phone: [illegible]  
20. Registrar's fax: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, pay the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12291

CERTIFICATE OF DEATH

12277

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson 4</b>		c. LENGTH OF STAY IN 1b <b>2½ yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1307 Aintree Rd. Hampton</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Albert Gustav Fox</b> Middle <b>Fox</b> Last <b>Fox</b>		4. DATE OF DEATH Month <b>11-16</b> Day <b>19</b> Year <b>61</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-18-1913</b>
9. AGE (In years last birthday) <b>48</b> yrs.		10. IF UNDER 1 YEAR Months <b>48</b> Days <b>17</b> Hours <b>47</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Food broker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own business</b>	
11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Gustav J. Fox</b>		14. MOTHER'S MAIDEN NAME <b>Lillian Fritzel</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>WWII "43-"44 091-03-6816</b>	
17. INFORMANT <b>Ellen B. Fox</b>		Address <b>above</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of colon with metastasis</b> <b>153.8</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>11 mos.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>12-15, 1960</b> to <b>11-16, 1961</b> , that (I) (we) last saw the deceased alive on <b>10-10, 1961</b> , and that death occurred at <b>7 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Alfred G. Osman, Jr.</b>		22b. DATE SIGNED <b>11-17-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Alfred G. Osman Jr</b>		22d. ADDRESS <b>1101 St Paul St Balt 12 Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11-18-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Dulaney Valley Mem.</b>		23d. LOCATION (City, town, or county) (State) <b>Cockeysville, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Brooks Funeral Service, Towson 4, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>NOV 20 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>			

1955



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

12292

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

12278

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. LENGTH OF STAY IN 1b <u>4 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Caton Ridge Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>BARBARA</u> First <u>FRANK</u> Middle <u>FRANK</u> Last		4. DATE OF DEATH <u>Nov.</u> Month <u>15</u> Day <u>1961</u> Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 15, 1866</u>
9. AGE (In years last birthday) <u>94</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Oscar Frank</u> Address <u>4023 Woodridge Rd. Zone 29</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>degenerative Cardiovascular dis</u> c) <u>Coron.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bed sores. 7 wounds hip left heel (not related)</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1/10</u> to <u>11/15</u> , 19 <u>61</u> that (I) (we) last saw the deceased alive on <u>11/13</u> , 19 <u>61</u> , and that death occurred at <u>4:45</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Cliff Ratliff, Jr.</u> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>CLIFF RATLIFF, JR.</u>		22d. ADDRESS <u>4605 EDMONSON AVE.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11-17-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Bohemian National Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Philip E. Creech</u> ADDRESS <u>1211 Cheseco Ave.</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 17 '61</u>	
		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

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(M)

No	Name	Unknown	Household	Female white	X	Dec 12 1921	94	USA
1	—	Unknown	Household	Female white	X	Dec 12 1921	94	USA

(1)

John E. Cook, 1000 Avenue  
B, New York City

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. The law also requires that the death certificate be retained by the hospital or attending physician. The law also requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

12293

12279

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> c. LENGTH OF STAY IN 1b <u>3001-4</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Foxleigh Nursing Home</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>3500 Carsdale Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>DAVID M FRANKEL</u>		4. DATE OF DEATH <u>11/18/61</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/13/87</u>
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumbing Supplies</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Canada</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Not known</u>		14. MOTHER'S MAIDEN NAME <u>Not known</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Not known</u>		16. SOCIAL SECURITY NO. <u>Not known</u>	
17. INFORMANT <u>Ada Frankel - same</u>		Address <u>Ada Frankel - same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRO - VASCULAR ACCIDENT</u> DUE TO (b) <u>ASCUD</u> DUE TO (c) <u>ASCUD</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>5 MIN</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>5/12</u> , 19 <u>61</u> , to <u>11/18</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>11/18</u> , 19 <u>61</u> , and that death occurred at <u>1 P.M.</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Bernard R Shochet, M.D.</u>		22b. DATE SIGNED <u>11/18/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Bernard R Shochet, M.D.</u>		22d. ADDRESS <u>6804 Park Heights Ave</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11-21-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Beth T Felo</u>		23d. LOCATION (City, town or county) (State) <u>Balto Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Levin</u>		24b. ADDRESS <u>2100 Eutaw Place</u>	
25a. REC'D BY REGISTRAR <u>NOV 21 '61</u>		25b. REGISTRAR'S SIGNATURE <u>William S. Thomas</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12294

## CERTIFICATE OF DEATH

12280

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Towson</b> c. LENGTH OF STAY IN 1b <b>7 yrs.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Stella Maris Hospice</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>3711 Harlem Avenue</b> d. STREET ADDRESS <b>3711 Harlem Avenue</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Margaret Frances Freund</b>				4. DATE OF DEATH Month <b>11</b> Day <b>16</b> Year <b>1961</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5/28/1881</b>		9. AGE (In years last birthday) <b>80</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housekeeper</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Henry Freund</b>				14. MOTHER'S MAIDEN NAME <b>Catherine Reichert</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>-</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>170X Metastatic Ca</b> DUE TO (b) <b>Ca Breast, Left</b> DUE TO (c) <b>ASCVD</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		20g. (County)	
21. I certify that (I) (this hospital) attended the deceased from <b>10-19-54</b> to <b>11/16</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>11/16</b> , 19 <b>61</b> , and that death occurred at <b>10:00 A.M.</b> from the causes and on the date stated above.									
22a. SIGNATURE <b>Robert J. Mahon</b>				22b. DATE SIGNED <b>11/16</b>		22c. PHYSICIAN'S NAME (Type) <b>Dr. Robert Mahon</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>				23b. DATE THEREOF <b>11/18/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>HOLY REDEEMER</b>		23d. LOCATION (City, town or county) (State) <b>BELAIR RD MD</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>DIPPEL BROS</b>				24b. ADDRESS <b>7110 BELAIR RD</b>		25a. REC'D BY REGISTRAR <b>NOV 20 1961</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur E. Kraske</b>	

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

12281

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b> c. LENGTH OF STAY IN 1b <b>Towson</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>8375 Hillendale Road</b>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b> d. STREET ADDRESS <b>8375 Hillendale Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>George C. Fulcher, Sr.</b>		4. DATE OF DEATH Month <b>11</b> Day <b>7</b> Year <b>19 61</b>					
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>5/25/1898</b>	9. AGE (In years last birthday) <b>63</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Meat Grader</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Newport News</b>			
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>George W. Fulcher</b>			14. MOTHER'S MAIDEN NAME <b>Hope Barfield</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>215-22-1745</b>		17. INFORMANT <b>George C. Fulcher Jr.</b> Address <b>Baldwin, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>260X</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>arteriosclerosis</b> (a), stating the underlying cause last. (c) <b>Diabetes Mellitus</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>?</b> <b>7</b>					INTERVAL BETWEEN ONSET AND DEATH <b>30 min</b>		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that (I) (this hospital) attended the deceased from <b>July</b> , 19 <b>57</b> to <b>Mar 6</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>Mar 4</b> , 19 <b>61</b> , and that death occurred at <b>7A-M</b> , from the causes and on the date stated above.							
22. SIGNATURE <b>George T. Gilmore</b> M.D.		22a. PHYSICIAN'S NAME (Type) <b>G.T. GILMORE</b>		22b. DATE SIGNED <b>11/7/61</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11-11-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Peninsula Mem. Park</b>			
23d. LOCATION (City, town or county) <b>Warwick</b>		(State) <b>Va.</b>					
24. FUNERAL DIRECTOR'S SIGNATURE <b>H.W. Jenkins &amp; Sons Co.</b>		ADDRESS <b>4905 York Rd. Balto</b>		25a. REC'D BY REGISTRAR <b>NOV 8 '61</b>			
25b. REGISTRAR'S SIGNATURE <b>Andrew S. Trans</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

1854

1990

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

CERTIFICATE OF DEATH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12296

CERTIFICATE OF DEATH

Item 23a Film 6302 12/7/61 iwk12282

1. PLACE OF DEATH a. COUNTY Baltimore		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills		c. LENGTH OF STAY IN 1b 2 mos.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Washington			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rosewood State Training School				d. STREET ADDRESS none				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Margaret		Middle Louise		Last Fultz		4. DATE OF DEATH Month 11		Day 23		Year 1961	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3--11--60		9. AGE (In years last birthday) 1 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none				10b. KIND OF BUSINESS OR INDUSTRY none				11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Junior Darley Fultz						14. MOTHER'S MAIDEN NAME Ruby Mae Haynes					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. none		17. INFORMANT Rosewood Records		Address Owings Mills, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonitis 7-53-1 DUE TO Diarrhea and Dehydration and Possible Aspiration Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) Microcephaly and Epilepsy										INTERVAL BETWEEN ONSET AND DEATH 10 days 1 month since birth	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (†) (this hospital) attended the deceased from 9/26 1961 to 11/23 1961, that (†) (we) lost saw the deceased alive on 11/23 1961, and that death occurred on 11/23 1961, from the causes and on the date stated above.											
22a. SIGNATURE Harry G. Butler						M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 11/24/61			
22c. PHYSICIAN'S NAME (Type) Harry G. Butler, M.D.						22d. ADDRESS Rosewood Lane, Owings Mills, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Buried		23b. DATE THEREOF 11/24-61		23c. NAME OF CEMETERY OR CREMATORY Salem		23d. LOCATION (City, town, or county) Glensville		(State) W.D.A.			
24. FUNERAL DIRECTOR'S SIGNATURE W.H. McKeel August 24						25a. REC'D BY REGISTRAR DATE NOV 30 '61		25b. REGISTRAR'S SIGNATURE C. S. Thomas			

18220

CERTIFICATE OF DEATH

18220

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(1)

Henry B. Parker

Wm. H. Parker

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

12297		12283	
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b> c. LENGTH OF STAY IN 1b <b>235 Burke Ave</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>235 Burke Ave</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson, Baltimore 4, Md</b> d. STREET ADDRESS <b>235 Burke Ave</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>HAROLD F GAMBRILL</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>14</b> Year <b>1961</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 17, 1895</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Real Estate Dealer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Real Estate</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Md.</b>
13. FATHER'S NAME <b>Horatio Nelson Gambrill</b>		14. MOTHER'S MAIDEN NAME <b>unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>W.W. 1 214-03-7692</b>	
17. INFORMANT <b>Phillip D. Gambrill</b>		Address <b>Balto. 12, Md</b> <b>5311 Kenilworth Av.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary occlusion</b> Conditions, if any, which gave rise to immediate cause (b) <b>Generalized arteriosclerosis</b> (c) <b>5 yrs.</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>2 days</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Feb 7, 1961</b> to <b>Nov 14, 1961</b> , that (I) (we) last saw the deceased alive on <b>Nov 14, 1961</b> , and that death occurred at <b>5 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Frederick J. Vollmer</b> M.D.		22b. DATE SIGNED <b>Nov. 14, 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>6100 YORK RD. BALTO-12, MD</b>		22d. ADDRESS <b>FREDERICK J. VOLLMER</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Nov. 16/61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park Cem.</b>	23d. LOCATION (City, town or county) (State) <b>Baltimore, Md.</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook-Towson, Inc</b>		25a. REC'D BY REGISTRAR DATE <b>NOV 16 '61</b>	
ADDRESS <b>1050 York Rd.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kenna</b>	

VR A15 (4)  
15M 9/60

12383

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Station

Lowson, Station, 12383

Lowson

222 222 Ave

222 222 Ave

Nov. 12, 1938

Nov. 12, 1938

Nov. 12, 1938

Nov. 12, 1938

Nov. 12, 1938

U.S.A.

Station, 12383

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Nov. 12, 1938

Nov. 12, 1938

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Station, 12383

Nov. 12, 1938



**#12**  
**FOR STATE**  
**HEALTH DEPT.**

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MEDICAL CERTIFICATION

**MARYLAND STATE DEPARTMENT OF HEALTH**

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

**12298**

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

**12284**

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Timonium</b>		c. LENGTH OF STAY in 1b <b>9 months</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Baltimore</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Timonium,</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>214 614 East Ridgely Road</b>		e. STREET ADDRESS <b>614 East Ridgely Road</b>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		3. NAME OF DECEASED (Type or print) First Middle Last <b>Adam Ernest Gerald</b>		4. DATE OF DEATH Month Day Year <b>November 9 1961</b>		5. SEX <b>male</b>	
6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 3, 1913</b>		9. AGE (In years last birthday) yrs. <b>48</b>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Director Trade Relations Hamm's Brewery</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Redondo Beach, Calif.</b>		11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Adam Gerald</b>		14. MOTHER'S MAIDEN NAME <b>Emily H. Pinnow</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW II</b>		16. SOCIAL SECURITY NO. <b>135-01-8063</b>		17. INFORMANT <b>Mrs. M. Eleanor Gerald, 214 614 E. Ridgely Rd. Timonium, Md</b>		18. CAUSE OF DEATH (Enter only one cause, explaining for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gunshot Wound of Brain</b> 976X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) } (c) }		INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20b. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20d. (City or town)		20e. (County)		20f. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) <b>Charles F. O'Donnell, M.D.</b> DATE SIGNED <b>11/10/61</b>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		22b. DATE THEREOF <b>11-10-61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Forest Lawn Cemetery</b>		22d. LOCATION (City, town, or country) (State) <b>St. Paul, Minnesota</b>		23. FUNERAL DIRECTOR ADDRESS <b>Wm. Cook-Towson, Inc. 1050 York Road, Towson,</b>		24a. REC'D BY REGISTRAR <b>NOV 14 '61</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>											

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may be signed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

12299

12285

1. PLACE OF DEATH a. COUNTY <b>Baltimore County</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> COUNTY <b>BALTIMORE</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Wilson, Maryland</b>				c. LENGTH OF STAY IN 1b <b>8 MONTHS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Mt. Wilson State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>THOMAS</b> Middle <b>WOLFORD</b> Last <b>Gill</b>				4. DATE OF DEATH Month <b>11</b> Day <b>11</b> Year <b>1961</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/27/95</b>	9. AGE (In years last birthday) <b>65</b> yrs.	IF UNDER 1 YEAR Months Days Hours	IF UNDER 24 HRS. Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>CITY OF BALTO.</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>NOAH Gill</b>				14. MOTHER'S MAIDEN NAME <b>CORA SMART</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>216-16-8912</b>		17. INFORMANT Address <b>Hospital Records, Mt. Wilson State Hospital</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Mod Advanced Pulmo Tuberculosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma of the Head of the</b> (c) <b>Pancreas</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <b>8 mo approx</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>3/27/61</b> 19 to <b>11/11/61</b> 19, that (I) (we) last saw the deceased alive on <b>11/11/61</b> , and that death occurred at <b>4:30 P.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>W Newcomer</b>				22b. DATE SIGNED <b>11/11/61</b>		22c. PHYSICIAN'S NAME (Type) <b>William Newcomer, M.D., Superintendent Mt. Wilson State Hospital, Mt. Wilson, Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>11/14/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BALTO. CEMT.</b>		23d. LOCATION (City, town, or county) (State) <b>BALTO CITY MD.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>E.W. Hoffmann 3218 Hudson St. (24)</b>				25a. REC'D BY REGISTRAR <b>NOV 13 61</b>		25b. REGISTRAR'S SIGNATURE <b>William S. Thomas</b>	

12345

CERTIFICATE OF DEATH

12345

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

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12300  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

12286

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) CITY a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Wilson, Maryland</b>				c. LENGTH OF STAY IN 1b <b>35 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Mt. Wilson State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>HARRISON</b> Last <b>GILLESPIE</b>				4. DATE OF DEATH Month <b>Nov</b> Day <b>2</b> Year <b>1961</b>			
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4/13/89</b>	
9. AGE (In years lost birthday) <b>72</b> yrs.		10. IF UNDER 1 YEAR Months <b>7</b> Days <b>2</b> Hours <b>15</b> Min.		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CARPENTER</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Contracting</b>			
13. FATHER'S NAME <b>George Gillespie</b>				14. MOTHER'S MAIDEN NAME <b>Mary Getty</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>				16. SOCIAL SECURITY NO. <b>216-01-8668</b>			
17. INFORMANT <b>Mrs. Helen Gillespie-4819 Windsor Mill Rd. Hospital Records, Mt. Wilson State Hospital</b>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of the Lung with Metastasis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>Mod. Advanced Pulmo. Tuberculosis.</b> (b) <b>DUE TO</b> (c) <b>DUE TO</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>002X</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20a. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20d. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>9/28/1961</b> to <b>11/2/1961</b> that (I) (we) last saw the deceased alive on <b>11/2/1961</b> , and that death occurred at <b>7AM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>W. Newcomer</b>				22b. DATE SIGNED <b>11/2/61</b>			
22c. PHYSICIAN'S NAME (Type) <b>Wm. Newcomer, M.D. Superintendent</b>				22d. ADDRESS <b>Mt. Wilson State Hospital, Mt. Wilson, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>11-6-61</b>			
23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn</b>				23d. LOCATION (City, town, or county) (State) <b>Woodlawn, Maryland</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Tuckner, Sons North &amp; Penna Bldg 17 Md</b>				25a. REC'D BY REGISTRAR DATE <b>NOV 6 '61</b>			
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>							

13581

CERTIFICATE OF DEATH

13300

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
CERTIFICATE OF DEATH														
12301														
12287														
1. PLACE OF DEATH a. COUNTY Baltimore					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodbrook					b. COUNTY Baltimore									
c. LENGTH OF STAY IN 1b					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Woodbrook									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6317 N. Charles Street #12					d. STREET ADDRESS 6317 N. Charles Street #12									
3. NAME OF DECEASED (Type or print) First Middle Last Lillie Kritwise Girardin					4. DATE OF DEATH Month Day Year November 15, 1961									
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 22, 1875		9. AGE (In years last birthday) 86 yrs.						
								IF UNDER 1 YEAR Months Days						
								IF UNDER 24 HRS. Hours Min.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife					10b. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland				
12. CITIZEN OF WHAT COUNTRY? U. S. A.					13. FATHER'S NAME Ambrose Kritwise					14. MOTHER'S MAIDEN NAME Mary Bauman				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No					16. SOCIAL SECURITY NO.					17. INFORMANT Miss Evelyn Girardin-6317 N. Charles Street				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)					Broncho Pneumonia Myocardial Infarction Arterio Sclerosis & V. Disease Hypertrophic Arteritis					INTERVAL BETWEEN ONSET AND DEATH 2 weeks 3 weeks 10 days				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Hypertrophic Arteritis					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				
20f. (City or town) Baltimore					20g. (County) Baltimore					20h. (State) Maryland				
21. I certify that (I) (this hospital) attended the deceased from February 19, 1961 to November 15, 1961, that (I) (we) last saw the deceased alive on November 13, 1961, and that death occurred at 11:55 A.M. from the causes and on the date stated above.														
22a. SIGNATURE C. Wilbur Stewart					22b. DATE SIGNED 11/15/61									
22c. PHYSICIAN'S NAME (Type) C. Wilbur STEWART					22d. ADDRESS 6 E. Rad St.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					23b. DATE THEREOF 11-18-61					23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cemetery				
23d. LOCATION (City, town or county) Baltimore, Maryland					23e. REC'D BY REGISTRAR NOV 17 '61					23f. REGISTRAR'S SIGNATURE William J. Tucker				
24. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tucker					24b. ADDRESS Balto. 17, 72d.									

1885

1885



Mr. James  
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Mr. James

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 12302 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 12288

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural- Owings Mills</b>		c. LENGTH OF STAY IN 1b <b>2 Hours</b> <del>18 years</del>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Randallstown -- Rural</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Garrison Forest Road</b>				d. STREET ADDRESS <b>3614 Blackstone Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Mr. Norman</b> Middle <b>Frank</b> Last <b>Gorsuch</b>				4. DATE OF DEATH Month <b>November</b> Day <b>17</b> Year <b>1961</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 18, 1906</b>		9. AGE (In years last birthday) <b>55</b> yrs.	IF UNDER 1 YEAR Months <b>55</b> Days <b>55</b> Hours <b>55</b> Min.	IF UNDER 24 HRS. Hours <b>55</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Manager</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Real Estate</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Lewis J. Gorsuch</b>				14. MOTHER'S MAIDEN NAME <b>Edith V. Mallonee</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>3614 Blackstone Rd. Randallstown, Md.</b> <b>Mrs. Margaret G. Gorsuch</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>420.1</b> (c), stating the underlying cause last. DUE TO (c) <b>420.1</b>							INTERVAL BETWEEN ONSET AND DEATH <b>15 Min.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <b>None</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <b>o. m.</b> <b>p. m.</b> <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>None</b>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>D.D. Caples</b> EXAMINER'S NAME (Type) <b>D.D. Caples</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
DATE SIGNED <b>11/18/61</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-20-61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. John's Esp. Ch. Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore County, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Erving Byers</b>				24a. REC'D BY REGISTRAR <b>NOV 22 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any doubt is necessary, please execute it in duplicate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12303

## CERTIFICATE OF DEATH

12289

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> <b>Baltimore</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Sparks</b>				c. LENGTH OF STAY IN 1b <b>Life</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>York Road</b>				e. STREET ADDRESS <b>Sparks Maryland</b>			
3. NAME OF DECEASED (Type or print) <b>William Mays</b>				4. DATE OF DEATH <b>Nov. 20 1961</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <b>3-1-1874</b>	
9. AGE (In years last birthday) <b>87</b>		10. IF UNDER 1 YEAR <b>Months</b> <b>Days</b> <b>Hours</b> <b>Min.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Owner of Farm</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>			
13. FATHER'S NAME <b>Thomas T. Gorsuch</b>				14. MOTHER'S MAIDEN NAME <b>Temperance Mays</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>219-32-1235</b>			
17. INFORMANT <b>Mrs. Edith Gorsuch York Rd. Sparks Md.</b>				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arterio-sclerotic Cardio Vascular disease</b>				INTERVAL BETWEEN ONSET AND DEATH			
422.1 DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				(b) DUE TO			
				(c) DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>May 1960</b> to <b>11/20</b> , 19 <b>61</b> , that (I) <b>(we)</b> last saw the deceased alive on <b>11/20</b> 19 <b>61</b> , and that death occurred at <b>6:30</b> P.M. from the causes and on the date stated above.							
22a. SIGNATURE <b>A. M. France</b> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>11/21/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>A. M. FRANCE</b>				22d. ADDRESS <b>Parkton Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11-22-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gorsuch Family Lot</b>		23d. LOCATION (City, town or county) (State) <b>Sparks, Md.</b>	
24 FUNERAL DIRECTOR'S SIGNATURE <b>Brooks Funeral Service</b> ADDRESS <b>Towson 4, Md.</b>				25a. REC'D BY REGISTRAR <b>NOV 24 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. France</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

(M)

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12881

Salisbury

Salisbury

Salisbury

Sparks

Life

Sparks

York Road

York Road

William

Age

Age

White

3-1-1875

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Owner of Farm

Farm

Salisbury

Thomas T. Jackson

Thomas T. Jackson

do

210-32-1212

do. with Jackson York Rd. Sparks Md.

John Jackson

Brooks Funeral Service  
11-22-61  
Burial  
Jackson Family Inc  
Sparks, Md.

Brooks Funeral Service Jackson H. Md.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
12304 CERTIFICATE OF DEATH 12290											
1. PLACE OF DEATH e. COUNTY <b>BALTO.</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ESSEX</b> c. LENGTH OF STAY IN 1b <b>4.5 weeks</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>68 SILVER LANE (SON'S RESIDENCE)</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <b>MD.</b> b. COUNTY <b>BALTO.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ESSEX</b> d. STREET ADDRESS <b>302 HOLLY NECK RD.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>JOHN B. GREEN</b>						4. DATE OF DEATH <b>Nov. 22 1961</b>					
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>MAY 12, 1980</b>		9. AGE (In years last birthday) <b>81</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>AMERICAN BREWERY</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>BALTO. MD.</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>JOSEPH GREEN</b>						14. MOTHER'S MAIDEN NAME <b>ANNA DAVIS</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>				16. SOCIAL SECURITY NO. <b>210-18-6248</b>		17. INFORMANT <b>Mrs. LOUISA GREEN</b> Address <b>302 HOLLY NECK RD.</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1 ACUTE CORONARY OCCLUSION</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>ARTERIOSCLEROTIC C.V. DISEASE</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)										INTERVAL BETWEEN ONSET AND DEATH: <b>11-22-61</b> <b>6-14-61</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>NONE</b>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>NONE</b>							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>NONE</b> 19 p.m. <b>NONE</b>				20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <b>NONE</b>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>NONE</b>		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>6-14-61</b> , 19 <b>11-22-61</b> , that (I) (we) last saw the deceased alive on <b>11-22-61</b> , 19 <b>11-22-61</b> , and that death occurred at <b>11-22-61</b> M, from the causes and on the date stated above.											
22a. SIGNATURE <b>E. A. Schimunek M.D.</b>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <b>E. A. SCHIMUNEK M.D.</b>						22d. ADDRESS <b>842 S. EAST AVE BALTO. 24 MD.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>				23b. DATE THEREOF <b>NOV. 25, 1961</b>		23c. NAME OF CEMETERY OR <b>CEDAR HILL</b>		23d. LOCATION (City, town or county) (State) <b>A.A. CO. MD.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>G.W. Hoffmann</b>						ADDRESS <b>3218 HUDSON ST.</b>		25a. REC'D BY REGISTRAR <b>NOV 24 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>	

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HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any day is necessary, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME  
5M 9/60

12305 MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 12291

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Edgemere (19)</b>		c. LENGTH OF STAY IN b <b>1 year</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Edgemere (19)</b>		d. STREET ADDRESS <b>2508 Wagner Avenue</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>2508 Wagner Avenue</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ANDREW</b> Middle <b>T.</b> Last <b>GREER</b>				4. DATE OF DEATH Month <b>November</b> Day <b>6th</b> Year <b>19 61</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 17, 1901</b>		9. AGE (In years last birthday) <b>60</b>	IF UNDER 1 YEAR Months <b>6</b> Days <b>19</b> Hours <b>61</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Steel</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>unknown</b>				14. MOTHER'S MAIDEN NAME <b>unknown</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>yes WWII</b>		16. SOCIAL SECURITY NO. <b>217-05-4276</b>		17. INFORMANT <b>Nanie M. Smith</b>		Address <b>same as #2</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cornay Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>A s-c-v-Disease</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>M B Davis</b>				M.D. <b>Dundalk 22, Md.</b>		DATE SIGNED <b>11/7/61</b>	
EXAMINER'S NAME (Type) <b>Melvin B. Davis, M.D.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>Dundalk 22, Md.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/9/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		22d. LOCATION (City, town, or country) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR <b>Walter Brooks Bradley, Inc., Dundalk 22, Md.</b>				ADDRESS <b>Dundalk 22, Md.</b>		24a. REC'D BY REGISTRAR <b>NOV 9 '61</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hanna</b>			

12306 MEDICAL EXAMINATION REPORT

DATE: 11/11/61

NAME: [REDACTED]

AGE: 34 years

SEX: Male

DATE OF BIRTH: 11/11/27

PLACE OF BIRTH: [REDACTED]

EDUCATION: [REDACTED]

DATE OF EXAMINATION: 11/11/61

11/11/61

PHYSICAL EXAMINATION: [REDACTED]

LABORATORY TESTS: [REDACTED]

DIAGNOSIS: [REDACTED]

RECOMMENDATIONS: [REDACTED]

DATE OF REPORT: 11/11/61

REPORTING PHYSICIAN: [REDACTED]

WATER WORKS: [REDACTED]

12306

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

12292

1. PLACE OF DEATH a. COUNTY <b>Baltimore County</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Wilson, Maryland</b> c. LENGTH OF STAY IN 1b <b>1 1/2 mo.</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Mt. Wilson State Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington D.C.</b> d. STREET ADDRESS <b>410 Cedar Str.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>CLARENCE</b> Middle <b>J.</b> Last <b>HARTSON</b>		4. DATE OF DEATH Month <b>11</b> Day <b>8</b> Year <b>1961</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9.15.1878</b>
9. AGE (In years lost birthday) <b>83</b> yrs.		10. IF UNDER 1 YEAR Months <b>8</b>	11. IF UNDER 24 HRS. Days <b>15</b> Hours <b>2</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Michigan</b>	
11. BIRTHPLACE (State or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>CALVIN HARTSON</b>		14. MOTHER'S MAIDEN NAME <b>MARY ANN SANBURN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT <b>Hospital Records, Mt. Wilson State Hospital</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Moderately advanced pulmonary tuberculosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>9.26.1961</b> to <b>11.8.1961</b> , that (I) (we) lost saw the deceased alive on <b>11.8.1961</b> , and that death occurred on <b>8.56.1961</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Wm. Newcomer</b>		22b. DATE <b>11.8.1961</b> SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Wm. Newcomer, M.D., Superintendent</b>		22d. ADDRESS <b>Mt. Wilson State Hospital, Mt. Wilson, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Nov. 10, 1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Prince Geo. Co. Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>J. Arthur Walters</b>		25. REC'D BY REGISTRAR <b>Arthur S. Kraus</b>	
25a. ADDRESS <b>254 Carroll St NW DC</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	
25c. DATE <b>NOV 10 '61</b>		25d. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

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7024 Carroll Ave

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

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12293

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b> c. LENGTH OF STAY IN 1b <b>3 Days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Veterans Administration Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>1431 Madison Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ALBERT L. HAUGHTON</b>		4. DATE OF DEATH Month Day Year <b>November 14 19 61</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 28, 1894</b>
9. AGE (In years last birthday) <b>67</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maintenance Work</b>	
11. BIRTHPLACE (Country, State, foreign country) <b>Edenton, N. Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Albert Haughton</b>		14. MOTHER'S MAIDEN NAME <b>Theresa Paxton</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>213-28-9552</b>	
17. INFORMANT <b>Clinical Records, VAH, Baltimore 18, Maryland</b> <b>FORT HOWARD DIVISION</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF THE ESOPHAGUS</b> <b>150X</b> BILATERAL PNEUMONIA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>DUE TO</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 YEARS</b> <b>4 DAYS</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>November 11, 1961</b> , to <b>November 14, 1961</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Nov. 14, 1961</b> , and that death occurred at <b>5:35 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Sebastian Russo</b> M.D.		22b. DATE SIGNED <b>11/15/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>SEBASTIAN RUSSO, M.D.</b>		22d. ADDRESS <b>VAH, BALTIMORE 18, MARYLAND, FT. HOWARD DIV.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11-20-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore 28, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>George G. Kelson</b> ADDRESS <b>George G. Kelson Funeral Home, 1348 N. Calhoun St.</b>		25a. REC'D BY REGISTRAR <b>NOV 16 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Wm. S. Thomas</b>			

Baltimore 17, Md.

(M)

Belmont

For: Home

3 days

Belmont

Belmont

1931 Madison Avenue

Verona (Belmont) Hospital

Albany

1.

November

November 14

1931

Home

Home

October 18, 1931

Belmont Home, Belmont, N. Carolina

Belmont

Belmont

Belmont

Belmont, N. Carolina, 1931, Belmont, N. Carolina

1931-1932

Nov 1

Yes

COMMISSION OF THE B. BOARD

STANDARD BUREAU

4 days

November 14, 1931

Nov. 14

*[Signature]*

Belmont, N. Carolina, 1931, Belmont, N. Carolina

Belmont, N. Carolina, 1931, Belmont, N. Carolina

Belmont, N. Carolina, 1931, Belmont, N. Carolina

Belmont

George D. Nelson Funeral Home, 1345 N. Calhoun St., Baltimore 17, Md.

Belmont 17, Md.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12308

## CERTIFICATE OF DEATH

12294

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b> c. LENGTH OF STAY IN 1b <b>9 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring, Maryland</b> d. STREET ADDRESS <b>2514 Lindell St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Mary E. Hayes</b>				4. DATE OF DEATH Month <b>November</b> Day <b>15</b> Year <b>1961</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 7, 1879</b>	
9. AGE (In years last birthday) <b>82</b> yrs.		IF UNDER 1 YEAR Months <b>15</b> Days <b>15</b>		IF UNDER 24 HRS. Hours <b>15</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>North Carolina</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>George W. Bryant</b>				14. MOTHER'S MAIDEN NAME <b>Mary E. Carter</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Inanition and dehydration</b> DUE TO (b) <b>Parkinson's Disease</b> DUE TO (c) <b>Cerebral arteriosclerosis</b> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Carcinoma of the urinary bladder</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Nov. 6, 1961</b> , to <b>Nov. 15, 1961</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Nov. 15, 1961</b> , and that death occurred at <b>1:20 p.m.</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Stella Wachslar</b>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>11-15-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Stella Wachslar, M. D.</b>				22d. ADDRESS <b>SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/18/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln</b>		23d. LOCATION (City, town or county) (State) <b>Colmar Manor, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Francis Gasch's Sons</b>				ADDRESS <b>Hyattsville, Maryland</b>		25a. REC'D BY REGISTRAR <b>DATE NOV 21 '61</b>	
						25b. REGISTRAR'S SIGNATURE <b>Carlton S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/60

12304

12304

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George W. Ryan

George W. Ryan

11/18/81

11/18/81

Francis C. Ryan

Francis C. Ryan

TO HO. **LEGAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. The 4 may be retained by the hospital or attending physician.  
TO **FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

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12295  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
12309  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural-White Hall</u> c. LENGTH OF STAY IN 1b <u>60yrs</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural-White Hall</u> d. STREET ADDRESS <u>10 Old York Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>A. Mabel T. Heise</u>		4. DATE OF DEATH <u>November 1, 1961</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 23, 1896</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		11. BIRTH PLACE (County & State, or foreign country) <u>White Hall, Md.</u>	
13. FATHER'S NAME <u>John W. Trout</u>		14. MOTHER'S MAIDEN NAME <u>Hanna Hollingshead</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Ca - 6 pleural effusion</u> 175.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Ca of Anom.</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>9 mo</u> <u>2 yr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>May 1961</u> to <u>11/1</u> , 19 <u>61</u> , that (I) <u>—</u> last saw the deceased alive on <u>11/1</u> , 19 <u>61</u> , and that death occurred at <u>7:30P</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>C. Herbert Mueller Jr</u>		22b. DATE SIGNED <u>11/2/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>C. HERBERT MUELLER JR</u>		22d. ADDRESS <u>PARKTON, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Nov-4-1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. John the Baptist Cem.</u>		23d. LOCATION (City, town or county) (State) <u>New Freedom, Pa.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Jacob Fortenstein</u>		25a. REC'D BY REGISTRAR <u>—</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	
DATE <u>NOV 6 '61</u>			

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Baltimore

Maryland

Baltimore

Rural-Whitehall

Rural-Whitehall

Old York Rd

Old York Rd

A Mabel

T. Heise

November 1, 61

F W

Dec. 23, 1896

Teacher

John W. Trent

Public School White Hall, Md. U.S.A.

No

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John W. Trent

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Nov. 4-1861 St. John the Baptist New Freedom Pa

C. HERBERT

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
12310 CERTIFICATE OF DEATH 12296													
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>MARYLAND</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baynesville</u>						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baynesville</u>							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>8517 Loch Raven Blvd.</u>						d. STREET ADDRESS <u>18517 Loch Raven Blvd.</u>							
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>B.</u> Last <u>Herbst</u>						4. DATE OF DEATH Month <u>Nov.</u> Day <u>17</u> Year <u>1961</u>							
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 9, 1885</u>		9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Timekeeper</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>George Herbst</u>						14. MOTHER'S MAIDEN NAME <u>Conigunda Zimmerman</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>(If yes give number or date of service)</u>		17. INFORMANT Address <u>Mrs William B. Bartman</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary artery occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>420.1</u> DUE TO (c) <u>420.1</u> DUE TO (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH <u>6 mos</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Bronchogenic carcinoma</u>													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>Baltimore</u>		20g. (County) <u>Baltimore</u>		20h. (State) <u>Md.</u>			
21. I certify that (I) (this hospital) attended the deceased from <u>11/17, 1961</u> to <u>11/17, 1961</u> , that (I) (we) last saw the deceased alive on <u>11/17, 1961</u> , and that death occurred at <u>5:45</u> P.M. from the causes and on the date stated above.													
22a. SIGNATURE <u>Gordon Grau</u> PHYSICIAN'S NAME (Type) <u>Gordon Grau, M.D.</u>						22b. DATE SIGNED <u>11/17/61</u>							
22c. ADDRESS <u>8523 Loch Raven Blvd. Balto. 4</u>						22d. ADDRESS <u>8523 Loch Raven Blvd. Balto. 4</u>							
23a. BURIAL, CREMATION, REMOVAL, (Specify) <u>burial</u>		23b. DATE THEREOF <u>11-20-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u>							
24. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>						25a. REC'D BY REGISTRAR DATE <u>NOV 21 '61</u>						25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

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Leonard, Inc. 2307

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TO HC RETAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

12311

12297

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b> c. LENGTH OF STAY IN TB <b>7 Days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Veterans Administration Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 27</b> d. STREET ADDRESS <b>2751 Arbutus Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>JOSEPH W. HIGDON</b>		4. DATE OF DEATH Month <b>November</b> Day <b>17</b> Year <b>19 61</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 28, 1919</b> 9. AGE (In years last birthday) yrs. <b>42</b> IF UNDER 1 YEAR Months <b>4</b> Days <b>19</b> Hours <b>61</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Grasonville, Maryland</b> 12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
13. FATHER'S NAME <b>Edward Higdon</b>		14. MOTHER'S MAIDEN NAME <b>Wilhelmina Tarbutton</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>Yes WW II</b>		16. SOCIAL SECURITY NO. <b>219-05-4941</b> 17. INFORMANT <b>Clinical Records, VAH, Baltimore 18, Maryland</b> <b>FORT HOWARD DIVISION</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RIGHT LOBAR PNEUMONIA, MASSIVE</b> DUE TO (b) <b>CARCINOMA, PANCREAS, WITH METASTASIS TO LIVER, ADRENAL, THORACIC WALL, REGIONAL LYMPH NODES</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>UNKNOWN</b>			INTERVAL BETWEEN ONSET AND DEATH <b>4 DAYS</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <b>X</b> (this hospital) attended the deceased from <b>Novm 10 1961</b> to <b>Nov. 17 1961</b> , that <b>X</b> (we) last saw the deceased alive on <b>November 17 1961</b> , and that death occurred at <b>2:28 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Sebastian Russo</b> 22c. PHYSICIAN'S NAME (Type) <b>SEBASTIAN RUSSO, M.D.</b>		22b. DATE SIGNED <b>11/17/61</b> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22d. ADDRESS <b>VAH, BALTO. 18, MD., FORT HOWARD DIVISION</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>11/21/61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cemetery</b>	23d. LOCATION (City, town or county) <b>Baltimore 28, Maryland</b> (State)
24. FUNERAL DIRECTOR'S SIGNATURE <b>James L. McCully</b>		25a. REC'D BY REGISTRAR <b>NOV 20 '61</b> 25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>	

(M)

(1)

James L. Moccally, 237 Fairview Ave., Balco., Ill.

RECEIVED BY: J. L. Moccally  
DATE: 11/1/51  
FROM: J. L. Moccally, 237 Fairview Ave., Balco., Ill.

November 1, 1951

Nov 1 1951

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED  
DATE 11/1/51 BY J. L. Moccally

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

11-01-51

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED  
DATE 11/1/51 BY J. L. Moccally

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

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15881

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 Film G501 11/24/61 iwk

12312

CERTIFICATE OF DEATH

Reg. Dist. No. 12298

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTO.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PARKVILLE</u>				c. LENGTH OF STAY IN 1b <u>19 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7714 Bagley Ave</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PARKVILLE</u>		f. STREET ADDRESS <u>13016 ARIZONA Ave</u>	
3. NAME OF DECEASED (Type or print) <u>AMANDA J. HIMELE</u>				4. DATE OF DEATH <u>11-17-61</u>		5. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1865</u>	
9. AGE (In years last birthday) <u>96</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. BIRTHPLACE (State or foreign country) <u>V.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>AT Home</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Simon STRONIDER</u>				14. MOTHER'S MAIDEN NAME <u>MARY BRILL</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		INFORMANT Address <u>Eula Williams Spencer Lane</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>renal failure</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic arteriosclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>20 yrs.</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____				21. I certify that I attended the deceased from <u>Oct 1, 1951</u> to <u>Nov. 1961</u> , that I last saw the deceased alive on <u>Oct. 1961</u> , and that death occurred at <u>6 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William Thomas</u>				ADDRESS (Street, city or town, state) <u>3700 Harford Rd., Balto. Md.</u> DATE SIGNED <u>11/17/61</u>			
PHYSICIAN'S NAME (Type) _____				M.D. _____			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11/20/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>RIVERVIEW Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Shenandoah VA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>C.F. EVANS + Son</u>				ADDRESS <u>8802 Harford Rd</u>		24a. REC'D BY REGISTRAR <u>NOV 21 1961</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur E. Thomas</u>							

(M)

(1)

15315

CERTIFICATE OF DEATH

15308

Baltimore

Parkville

17th Street

Amesbury

X

Hammond

Zimmerman

17th Street

Amesbury

17th Street

Amesbury

17th Street

Amesbury

17th Street

Amesbury

17th Street

Amesbury

17th Street

Amesbury

17th Street



12313

12313

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

12299

1. PLACE OF DEATH a. COUNTY <u>Parkton Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Parkton Md.</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkton</u>				c. LENGTH OF STAY IN 1b <u>Life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Parkton</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>GUSTAV HERMAN HOFFMAN</u>				4. DATE OF DEATH Month Day Year <u>11 20 19 61</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-16-1896</u>	
9. AGE (In years last birthday) <u>65</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>							
13. FATHER'S NAME <u>John Hoffman</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>212-10-6769</u>			
17. INFORMANT <u>Mrs Carrie Hoffman</u>				Address <u>Parkton Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>204.0</u> DUE TO <u>glioblastoma - (Probable)</u>							
Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>Lymphocytic Leukemia</u> DUE TO (c) <u>5 mo</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>17 June 1961</u> to <u>20 Nov 1961</u> , that (I) (we) last saw the deceased alive on <u>20 Nov 1961</u> , and that death occurred at <u>3 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>C. Herbert Mueller Jr.</u>				22b. DATE SIGNED <u>11/20/61</u>			
22c. PHYSICIAN'S NAME (Type) <u>C. HERBERT MUELLER JR.</u>				22d. ADDRESS <u>PARKTON MD.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>11-24-1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>	
23d. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u>							
24. FUNERAL DIRECTOR'S SIGNATURE <u>Lassohn Funeral Home</u>				25a. REC'D BY REGISTRAR <u>NOV 22 61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15289

CERTIFICATE OF TITLE

15289

(M)

GUSTAV HARMAN HARTMAN

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

12314

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12300

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>-</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural - Cockeysville</i>		c. LENGTH OF STAY IN 1b <i>9 yrs.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Maryland Masonic Home</i>		d. STREET ADDRESS <i>2817 Reisterstown Ave.</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Margaret Elizabeth Hoffman</i>		4. DATE OF DEATH <i>Nov. 16 1961</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan 11, 1871</i>
9. AGE (In years last birthday) <i>90</i> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA.</i>	
13. FATHER'S NAME <i>George W. Armacost</i>		14. MOTHER'S MAIDEN NAME <i>Rachel Hutton</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>214-03-744</i>	
17. INFORMANT <i>Records Md. Masonic Home - Cockeysville</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Generalized arteriosclerosis</i> <i>450.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Bilateral broncho pneumonia</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Oct 1961</i> to <i>Nov 16 1961</i> , that (I) (we) last saw the deceased alive on <i>Nov 16 1961</i> , and that death occurred on <i>8:45 PM</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>Elizabeth B. Sherrill</i>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <i>Elizabeth B. Sherrill</i>		22d. ADDRESS <i>Cockeysville, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE THEREOF <i>11-20-61</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Emanuel Lutheran Cemetery,</i>		23d. LOCATION (City, town, or county) (State) <i>Manchester, Maryland</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Wm. Cook, Inc., 1217 St. Paul Street, Zone 2</i>		25a. REGISTRAR'S SIGNATURE <i>Arthur S. Hanes</i>	
25b. REGISTRAR'S SIGNATURE <i>Arthur S. Hanes</i>		25c. DATE <i>NOV 20 '61</i>	

1234

CERTIFICATE OF DEATH

1934

Deceased

Birth

(M)

Residence

Place of Birth

Age at Death

Duration of Illness

Occupation

Cause of Death

Date of Death

Place of Death

Signature

Witness

Physician

Coroner

Place of Burial

Sex

Color of Hair

Color of Eyes

Color of Skin

Color of Teeth

Color of Nails

Color of Hair

Color of Eyes

Color of Skin

Color of Teeth

Color of Nails

11-10-34

11-10-34

TO DEED BY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

Item 20b Film 302

12-13-61

12315

Item 20b Film 302  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 7, 8, 9, 22c & 22d. Film 302 11/20/61 12301

1. PLACE OF DEATH a. COUNTY <b>Baltimore County</b>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore County</b>		c. LENGTH OF STAY IN lb <b>250 ft. south of Sewer Rd., 1/4 mile east of North Point Blvd.</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Baltimore</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>612 East Pratt Street</b>		d. STREET ADDRESS <b>3V01-4</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) <b>Henry C. Holley</b>		4. DATE OF DEATH <b>November 16, 1961</b>		5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>DEC. 25 1909</b>		9. AGE (In years last birthday) <b>39 38</b>		10. IF UNDER 1 YEAR Months Days Hours Min.															
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>WELDER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>MARINE</b>		11. BIRTHPLACE (State or foreign country) <b>VA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>DREWY HOLLEY</b>		14. MOTHER'S MAIDEN NAME <b>LULA F. TRINHAN</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>?</b>															
17. INFORMANT <b>JAMES L HOLLEY GORDONSVILLE, VA.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carbonmonoxide Poisoning</b> DUE TO (b) <b>773.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <b>"He inhaled carbonmonoxide while in auto. by was of a hose from the exhaust pipe."</b>		20c. TIME OF INJURY Month, Day, Year <b>12:35 Nov. 16, 61</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Road</b>		20f. (City or town) <b>Baltimore Co., Maryland</b>		20g. (State) <b>Virginia</b>													
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		ACTUAL SIGNATURE <b>Howard G. Shaub</b>		M.D. <b>HOWARD G. SHAUB, M. D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>11/16/61</b>		22a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		22b. DATE THEREOF <b>11/16/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Maplewood Cemetery</b>		22d. LOCATION (City, town, or country) <b>Gordonsville, Virginia</b>		22e. FUNERAL DIRECTOR <b>James C. Pugliese</b>		22f. ADDRESS <b>1402 Eastern Ave</b>		24b. REC'D BY REGISTRAR <b>NOV 17 '61</b>		24c. REGISTRAR'S SIGNATURE <b>Carlton E. Kline</b>	

12301

12301

(M)

250 ft. south of corner of  
Main and 1st St.

Old and new streets

100 ft.

100 ft.

100 ft.

100 ft.

100 ft.

100 ft.

100 ft.

100 ft.

100 ft.

100 ft.

100 ft.

100 ft.

100 ft.

100 ft.

100 ft.

100 ft.

100 ft.

100 ft.

100 ft.

100 ft.

100 ft.

100 ft.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
12316					12302				
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b> c. LENGTH OF STAY IN 1b <b>28 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>301-4</b> d. STREET ADDRESS <b>3709 West Cold Spring Lane</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <b>Norris</b> Middle <b>J.</b> Last <b>Huffington</b>					4. DATE OF DEATH Month <b>November</b> Day <b>24</b> Year <b>19 61</b>				
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 26, 1892</b>		9. AGE (In years last birthday) <b>69</b> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>paroll clerk</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Alexander Huffington</b>					14. MOTHER'S MAIDEN NAME <b>Mary Malone</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> War <b>I</b>					16. SOCIAL SECURITY NO. <b>213-09-2797</b>		17. INFORMANT Address <b>Records: SPRING GROVE STATE HOSPITAL</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>4-2-2-2</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Decubitus ulcers</b> INTERVAL BETWEEN ONSET AND DEATH									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that <b>X</b> (this hospital) attended the deceased from <b>Oct. 24, 19 61</b> to <b>Nov. 24, 19 61</b> , that (I) (we) last saw the deceased alive on <b>Nov. 24, 19 61</b> , and that death occurred at <b>5:50 P.M.</b> , from the causes and on the date stated above.									
22a. SIGNATURE <b>Stella Wachslar</b> M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> <b>11-24-61</b>		22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) <b>Stella Wachslar, M. D.</b>					22d. ADDRESS <b>SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>11-28-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cemetery Baltimore, Maryland</b>		23d. LOCATION (City, town or county) (State)		
24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Wm J. Tucker &amp; Sons Baltimore 17, Maryland</b>					25a. REC'D BY REGISTRAR <b>DATE NOV 27 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>		

13816

13816



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 3 and 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
12317						12303					
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> c. LENGTH OF STAY IN 1b <u>23 YRS.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Spring Grove State Hospital</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>3101 4</u> d. STREET ADDRESS <u>1923 W. Lombard St</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Henry</u>			First <u>Henry</u> Middle <u>Huss</u> Last <u>Huss</u>			4. DATE OF DEATH Month <u>11</u> Day <u>25</u> Year <u>1961</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-1-1884</u>		9. AGE (In years last birthday) <u>77</u>		IF UNDER 1 YEAR Months <u>7</u> Days <u>17</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Huckster's helper</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Produce</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.H</u>		
13. FATHER'S NAME <u>Unknown</u>						14. MOTHER'S MAIDEN NAME <u>Unknown</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>						16. SOCIAL SECURITY NO. <u>NONE</u>					
17. INFORMANT <u>ELIZABETH WALTERS</u>						Address <u>1205 Cathann St.</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Decompensation</u> DUE TO (b) <u>Gastro-enteritis, unknown etiology</u> DUE TO (c) <u>Generalized Arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u>9</u> a.m. <u>19</u> p.m.			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>11-25</u> to <u>11-25</u> , 19 <u>61</u> that (I) (we) last saw the deceased alive on <u>11-25</u> , 19 <u>61</u> , and that death occurred at <u>535</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>Gerald E. Weinstein M.D.</u>						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22b. DATE SIGNED <u>11/25/61</u>		
22c. PHYSICIAN'S NAME (Type) <u>Gerald E. Weinstein M.D.</u>						22d. ADDRESS <u>Spring Grove State Hospital</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>11-28-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>WESTERN</u>		23d. LOCATION (City, town or county) (State) <u>BALTIMORE Md.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Charles H. Miller</u>						ADDRESS <u>2101 Fitch Ave. Balt. Md.</u>		25a. REC'D BY REGISTRAR <u>NOV 29 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

1831

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12318

## CERTIFICATE OF DEATH

Reg. Dist. No. 12304

1. PLACE OF DEATH o. COUNTY <i>Balto.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Balto.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonsville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X Woodlawn</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>House In The Pines</i>		d. STREET ADDRESS <i>16801 Windsor Mill Rd</i>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Minnie Florence Immler</i>		4. DATE OF DEATH Month Day Year <i>Nov. 22 1961</i>	
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3-6-1890</i>
9. AGE (In years last birthday) <i>71</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Home</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	11. BIRTHPLACE (State or foreign country) <i>Md.</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>Emory S. Purkey</i>		14. MOTHER'S MAIDEN NAME <i>Clara A. Joh</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>219-32-1098B</i>	
17. INFORMANT Address <i>Mr. Amos L. Immler Sr. 6801 Windsor Mill Rd.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CARCINOMA RECTUM &amp; GENERAL</i> DUE TO 154X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>CARCINOMATOSIS</i> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH <i>3 YEARS</i>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>APRIL 1</i> , 19 <i>61</i> , to <i>Nov 22</i> , 19 <i>61</i> , that I last saw the deceased alive on <i>Nov 22</i> , 19 <i>61</i> , and that death occurred at <i>12:45 P.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>Randallstown Md</i> DATE SIGNED <i>11/23/61</i> ACTUAL SIGNATURE <i>Thomas E. Wheeler</i> M.D. PHYSICIAN'S NAME (Type) <i>THOMAS F. WHEELER</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>11-25-61</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Woodlawn</i>	22d. LOCATION (City, town, or county) (State) <i>Woodlawn Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>John T. Stansbury</i>		ADDRESS <i>6411 Windsor Mill Rd.</i>	24a. REC'D BY REGISTRAR DATE <i>NOV 27 '61</i>
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thoma</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12319

## CERTIFICATE OF DEATH

12305

Items 12 & 14 Film G300 11/17/61 iwk

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u>		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital) give street address		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>George</u>		4. DATE OF DEATH Month <u>NOV</u> Day <u>13</u> Year <u>1961</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-19-1880</u>
9. AGE (last day) <u>81</u> yrs.	IF UNDER 1 YEAR Months <u>8</u> Days <u>13</u>	IF UNDER 24 HRS. Hours <u>13</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cause</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Maxine Soap</u>	11. BIRTHPLACE (City, State, or foreign country) <u>Ind.</u>	12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <u>Christopher Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Bennett</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Family - Same</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Apoplexy</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Arterio sclerotic Cardiovascular Disease</u> DUE TO (c) <u>Diabetis Mellitus</u>			INTERVAL BETWEEN ONSET AND DEATH <u>11-8-61</u> <u>3 yrs</u> <u>2 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>NOV 8</u> , 19 <u>61</u> , to <u>NOV 13</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>NOV 12</u> , 19 <u>61</u> , and that death occurred at <u>1A</u> M., from the causes and on the date stated above.			
22a. SIGNATURE <u>SM Baumgardner</u>		22b. DATE SIGNED <u>11/13/61</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>11/16/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Green Lawn</u>	23d. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>M. Kelly - 1306 Fort Ave.</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 14 '61</u>	
		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

1830s

1830s

(M)

Nov. 13, 41

Johnson

George

2-17-40

Nov. 13, 41

(I)

11-1-41

Cervical Aphyx

Anterior sclerotic Cervical Aphyx

Liberty Militia

Nov 4, 1941

AI

Nov 11, 41

11/13/41

✓

William

Nov 11, 41

Nov 11, 41

Nov 11, 41

Nov 11, 41

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
12320 CERTIFICATE OF DEATH 12306											
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b> c. LENGTH OF STAY IN 1b <b>Towson</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>702 E. Seminary Ave.</b>						2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b> d. STREET ADDRESS <b>702 E. Seminary Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>ELIZABETH M. KAUFMAN</b>						4. DATE OF DEATH Month <b>Nov.</b> Day <b>3,</b> Year <b>19 61</b>					
5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1877</b> <b>Nov. 7, 1877</b>		9. AGE (In years last birthday) <b>83</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Md.</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Ernest Steinwedel</b>						14. MOTHER'S MAIDEN NAME <b>Margaret Fink</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes give year or dates of service)				16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Irma K. Mund</b> Address <b>702 E. Seminary Ave.</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Arteriosclerotic Cardio Vascular Disease</b> (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21. I certify that (I) (this hospital) attended the deceased from <b>October 11/31, 1961</b> to <b>Nov 3<sup>rd</sup>, 1961</b> , that (I) (we) last saw the deceased alive on <b>11/31, 1961</b> , and that death occurred at <b>5:45 M.</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>M. K. Quinn</b>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>11/4/61</b>			
22c. PHYSICIAN'S NAME (Type) <b>M. KEVIN QUINN MD</b>						22d. ADDRESS <b>1927 YORK RD, TIMONIUM MD.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/6/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cem.</b>		23d. LOCATION (City, town or county) (State) <b>Balto. Md.</b>		24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Howard H. Hubbard 4107 Wilkens Ave.</b>			
25a. REC'D BY REGISTRAR <b>NOV 8 '61</b>						25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>					

(M)

Baltimore

Towson

702 E. Seminary Ave.

ELIZABETH M. KAUTMAN

F

W

X

Nov. 7, 1977

Nov. 7, 1977

housewife

Ernest Steinmeyer

Manager Pink

no

none

Travis H. Mund 702 E. Seminary Ave.

Carroll Seminary

Carroll Seminary

October 22, 1977

11/1/77

M. K. Quinn

M. K. Quinn

Baltimore, Md.

London Park Cem.

11/6/77

Baltimore

Howard H. Hubbard 4107 Wilkins Ave.

Nov. 7, 1977

12321

## CERTIFICATE OF DEATH

Reg. Dist. No. 12307

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkton</u>		c. LENGTH OF STAY IN 1b <u>35 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>York Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Clinton S. Kearney Sr.</u> First Middle Last		4. DATE OF DEATH <u>November 22, 1961</u> Month Day Year	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 21, 1895</u> 66 yrs.
9. AGE (In years last birthday) <u>66</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Maintenance Man</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Penna. R.R.</u>	
11. BIRTHPLACE (State or foreign country) <u>Beckleysville, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Kearney</u>		14. MOTHER'S MAIDEN NAME <u>Henrietta Mays</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>717-076347</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>CORONARY OCCLUSION</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) _____ (c) _____ DUE TO _____		INTERVAL BETWEEN ONSET AND DEATH <u>3 1/2</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>April</u> , 1961, to <u>Nov. 22</u> , 1961, that I last saw the deceased alive on <u>Nov. 22</u> , 1961, and that death occurred at <u>12:45 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>A. M. France</u> M.D.		ADDRESS (Street, city or town, state) <u>PARKTON, MD</u> DATE SIGNED <u>11/24/61</u>	
PHYSICIAN'S NAME (Type) <u>A. M. FRANCE</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>11-25-61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Whiteburg Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>White Hall, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Special Mortuaries, New Freedom, Pa.</u> ADDRESS		24a. REC'D BY REGISTRAR <u>Nov 27 '61</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. France</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
12322					12308				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)				
a. COUNTY		Baltimore			e. STATE		Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Timonium			b. COUNTY		Baltimore		
c. LENGTH OF STAY IN 1b					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		X Timonium		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
2070 York Road					1 2070 York Road				
3. NAME OF DECEASED					4. DATE OF DEATH				
(Type or print)		THOMAS EDWARD KELLY			Month Day Year		November 22, 19 61		
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH		9. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Male	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	February 8, 1891		70 yrs.	Months	Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?
Railroad Telegrapher-Ret. P.R.R.					Maryland		USA		
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
John Kelly					Mary Hessian				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address			
No		None		Miss Nora Kelly, Timonium, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 334X ARTERIOSCLEROTIC CEREBROVASCULAR DISEASE									7 YRS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY		Month, Day, Year		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
Hour e.m. p.m.		19		While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					
21. I certify that (I) (this hospital) attended the deceased from JUNE 1954 to MAY 22, 1961, that (I) (we) last saw the deceased alive on SEPT 3, 1961, and that death occurred at 8 A.M. from the causes and on the date stated above.									
22a. SIGNATURE					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type)					22d. ADDRESS		11-24-61		
William A. Pillsbury, M.D.					2060 York Rd., Timonium, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)			
Burial		Nov. 25, 1961		St. Joseph's Cemetery		Texas, Balto.Co., Md.			
24. FUNERAL DIRECTOR'S SIGNATURE					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
John Burns' Sons, Towson, Maryland					DATE NOV 27 '61		Arthur S. Kraus		

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Belgium

Belgium

Belgium

2000 York Road

2000 York Road

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THOMAS EDWARD KELLY

October 22, 1931

John Kelly

February 2, 1931

Belgium Telephone-Reg. I.R.B.

Belgium

USA

John Kelly

John Kelly

John Kelly, Belgium, Reg. I.R.B.

Belgium Telephone-Reg. I.R.B.

William A. Kelly, Reg. I.R.B.

2000 York Rd., Belgium, Belgium

2000 York Rd., Belgium, Belgium

2000 York Rd., Belgium, Belgium

John Kelly, Belgium, Belgium

John Kelly, Belgium, Belgium

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. The law also requires that the death certificate be retained by the hospital or attending physician. The law also requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

12323

12309

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Towson</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>907 Southerly Road</b>		d. STREET ADDRESS <b>907 Southerly Road</b>	
3. NAME OF DECEASED (Type or print) <b>FRED ALOYSIS KENNEDY</b>		4. DATE OF DEATH Month <b>November</b> Day <b>21</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 18, 1880</b>
9. AGE (In years last birthday) <b>81</b> yrs.		10. IF UNDER 1 YEAR Months <b>21</b> Days <b>14</b> Hours <b>14</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman- retired</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Pennsylvania</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>UNKNOWN</b>	
14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	
16. SOCIAL SECURITY NO. <b>126-05-6042</b>		17. INFORMANT <b>Mrs. Fred A. Kennedy, Towson, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> <b>420.1</b> DUE TO <b>Coronary atherosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertension</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>1 + days</b> <b>21 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1940</b> , 19 to <b>Nov 21, 1961</b> that (I) (we) last saw the deceased alive on <b>20 Nov. 1961</b> , and that death occurred at <b>7 p.m.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Louis P. Hamburger Jr.</b> M.D.		22b. DATE SIGNED <b>Nov. 24, 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>Louis P. Hamburger Jr.</b>		22d. ADDRESS <b>1001 St Paul St. Baltimore 2, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Nov. 24, 1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Dulaney Valley Memorial Garden</b>		23d. LOCATION (City, town or county) (State) <b>Texas, Balto. Co., Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>John Burns' Sons, Towson, Maryland</b>		25a. REC'D BY REGISTRAR <b>NOV 27 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. France</b>			

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Mrs. Fred A. Kennedy, Town, Del.

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Nov. 21, 1980, Llanerch Valley Memorial Garden, Texas, Calif. Co., 46.

John Burns, Town, Maryland



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18310





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Pages 3 and 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

12325

12311

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rosedale</b>				c. LENGTH OF STAY IN 1b <b>25 yrs</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>8067 Philadelphia Road</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rosedale</b>			
f. STREET ADDRESS <b>8067 Philadelphia Road</b>				a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <b>Johanna M Kistner</b>				<b>4. DATE OF DEATH</b> Month <b>11</b> Day <b>13</b> Year <b>19 61</b>			
<b>5. SEX</b> <b>Female</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>4-6-1904</b>	
<b>9. AGE</b> (In years last birthday) <b>57 yrs.</b>		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Baltimore Md.</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>Charles Tumbleson</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Mary E Bohlen</b>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				<b>16. SOCIAL SECURITY NO.</b> <b>None</b>		<b>17. INFORMANT</b> <b>Mr Louis Kistner</b>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <b>Hypertensive Cardiovascular Disease</b> (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Diabetes mellitus</b>				INTERVAL BETWEEN ONSET AND DEATH			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		<b>20f. (City or town) (County) (State)</b> <b>Nov 13, 1961</b>	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>June 1961</b> <b>to</b> <b>Nov 13, 1961</b> , <b>that (I) (we) last saw the deceased alive on</b> <b>Nov 13, 1961</b> , <b>and that death occurred at</b> <b>4:45 PM</b> , <b>from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <b>John L. Kirk, M.D.</b>				<b>22b. DATE SIGNED</b> <b>11/14/61</b>			
<b>22c. PHYSICIAN'S NAME</b> (Type)				<b>22d. ADDRESS</b>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>11-16-1961</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>ZION LUTH. CEM.</b>		<b>23d. LOCATION</b> (City, town or county) (State) <b>BALTO. MD.</b>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Lassahn Funeral Home</b>				<b>25a. REC'D BY REGISTRAR</b> <b>DATE NOV 17 '61</b>			
<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur L. Kline</b>							

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Handwritten signature or text, possibly "John C. Smith".

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
12326 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 12312

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Sparrows Point</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Sparrows Point</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 6, Maryland</b> d. STREET ADDRESS <b>8117 Pulaski Highway</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Bruce W. Knauff</b>				4. DATE OF DEATH <b>11/24/61</b> 19 <b>61</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9/10/94</b>	
9. AGE (In years last birthday) <b>67</b>		10. IF UNDER 1 YEAR Months <b>67</b> Days <b>67</b>		11. IF UNDER 24 HRS. Hours <b>67</b> Min. <b>67</b>		12. CITIZEN OF WHAT COUNTRY <b>U S A</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Beth. Steel Co.</b>			
11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>				12. CITIZEN OF WHAT COUNTRY <b>U S A</b>			
13. FATHER'S NAME <b>Unknown Knauff</b>				14. MOTHER'S MAIDEN NAME <b>Unknown Unknown</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>219-01-0985</b>			
17. INFORMANT <b>Mrs. Mildred L. Knauff</b>				Address <b>8117 Pulaski Highway</b>			
18. CAUSE OF DEATH [Enter only one cause pertaining to (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary Occlusion</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <b>10 min</b> (c) <b>10 min</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/></b>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Jack C Collins</b>				CHIEF MEDICAL EXAMINER <b>11-24-61</b>			
EXAMINER'S NAME (Type) <b>Jack C Collins</b>				DATE SIGNED <b>11-24-61</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>11-28-1961</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>Zion Evan. Lutheran</b>				22d. LOCATION (City, town, or country) (State) <b>Golden Ring Rd. Balto. Co. Md.</b>			
23. FUNERAL DIRECTOR <b>Lavaka Funeral Home</b>				ADDRESS <b>7401 Belair Rd.</b>			
24a. REC'D BY REGISTRAR <b>NOV 27 '61</b>				24b. REGISTRAR'S SIGNATURE <b>William L. Knauff</b>			

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12327

Item 3 Film 6500 11/9/61 iwk

12313

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LUTHERVILLE</b>	c. LENGTH OF STAY IN 1b <b>2 WKS.</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LUTHERVILLE.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>COLLEGE MANOR HOME.</b>		d. STREET ADDRESS <b>300 W. SEMINARY AVE.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>MARY HELEN KNIGHT</b>		4. DATE OF DEATH Month <b>11</b> Day <b>2</b> Year <b>1961</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>SEPT 28, 1901</b>
9. AGE (In years last birthday) <b>60</b> yrs.		10. IF UNDER 1 YEAR Months <b>60</b> Days <b>60</b> Hours <b>60</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PRAC. NURSE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOSP.</b>	
11. BIRTHPLACE (State or foreign country) <b>MD.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>?</b>		14. MOTHER'S MAIDEN NAME <b>?</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>—</b>		16. SOCIAL SECURITY NO. <b>215-07-6599</b>	
17. INFORMANT <b>WM. A. KNIGHT</b>		Address <b>716 CLOUDYFOLD DRIVE.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4-20.1</b> DUE TO <b>Coronary Occlusion</b> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <b>Coronary Heart Disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH <b>several hours</b> <b>May 3, 1957</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Sept 24</b> 19 <b>52</b> to <b>Nov 2</b> 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>Oct 2</b> 19 <b>61</b> and that death occurred at <b>11</b> A.M. from the causes and on the date stated above.			
22a. SIGNATURE <b>Leonard Wallenstein</b>		22b. DATE SIGNED	
22. PHYSICIAN'S NAME (Type) <b>LEONARD WALLENSTEIN</b>		22d. ADDRESS <b>848 W. 36th BALTO. (11)</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>11/6/61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>LODON PARK</b>	23d. LOCATION (City, town, or county) (State) <b>BALTO. MD</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Paul E. Chomowetz</b>		24b. ADDRESS <b>3617 Chestnut Ave.</b>	
25a. REC'D BY REGISTRAR DATE <b>NOV 3 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Charles L. Thomas</b>	

(M)

12345

BALTIMORE

MD

LUTHERVILLE 2 WKS.

COLLEGE MANOR HOME 300 W. GEMMANY AVE

MARY HELEN KNIGHT

FEMALE WHITE 2 SEPT 28 1901

PRAC NURSE HOSP MD

300-0000 Wm. A. Knight 212 Concord Drive

8012 11161 LODON PARK BALTO



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
CERTIFICATE OF DEATH													
12328													
12314													
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>Pennsylvania</b> b. COUNTY <b>New Oxford</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>New Oxford</b> d. STREET ADDRESS <b>75 X - J</b>									
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>				c. LENGTH OF STAY IN TB <b>175 Days</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Veterans Administration Hospital</b>													
3. NAME OF DECEASED (Type or print) <b>WILLIAM L. KOHLER</b>				4. DATE OF DEATH Month <b>November</b> Day <b>14</b> Year <b>1961</b>									
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 30, 1897</b>		9. AGE (In years last birthday) <b>64 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Air Conditioning</b>				11. BIRTHPLACE (County & State, or foreign country) <b>New Oxford, Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
13. FATHER'S NAME <b>William H. Kohler</b>				14. MOTHER'S MAIDEN NAME <b>Ella Lockhart</b>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>Yes WW I</b>				16. SOCIAL SECURITY NO. <b>z 161-20-0662</b>				17. INFORMANT <b>Clinical Records, VAH, Baltimore 18, Maryland</b> <b>FORT HOWARD DIVISION</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b> DUE TO 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Gangrene, left leg due to arterial embolus</b> <b>Operation - 1. Amputation, Stump, left leg, 5/26/61. 2. Revision, Stump, 7/24/61</b>										INTERVAL BETWEEN ONSET AND DEATH <b>RECENT</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>May 23 11:15</b>		20g. (County) <b>Nov. 14 1961</b>		20h. (State) <b>11:15</b>			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>May 23 11:15</b> to <b>November 14 1961</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Nov. 14 1961</b> , and that death occurred at <b>A.M.</b> , from the causes and on the date stated above.													
22a. SIGNATURE <b>Thomas F. Crahan</b>				22b. DATE SIGNED <b>11/14/61</b>									
22c. PHYSICIAN'S NAME (Type) <b>THOMAS F. CRAHAN, M.D.</b>				22d. ADDRESS <b>VAH, BALTO. 18, MD., FT. HOWARD DIVISION</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE THEREOF <b>11/16/1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>New Oxford Cemetery</b>		23d. LOCATION (City, town or county) <b>New Oxford, Pennsylvania</b>		23e. REC'D BY REGISTRAR <b>Nov 17 '61</b>		23f. REGISTRAR'S SIGNATURE <b>Carling S. Hume</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Fred F. Feiser</b>				24b. ADDRESS <b>New Oxford, Pa.</b>									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12329  
CERTIFICATE OF DEATH

Reg. Dist. No. 12315

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. LENGTH OF STAY IN 1b <u>65</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6812 Duluth Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Louis</u> First <u>( no middle )</u> Middle <u>Kulacki</u> Last		4. DATE OF DEATH Month <u>11</u> Day <u>30</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/ /1878</u>
9. AGE (In years lost birthday) <u>83</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Agent</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Insurance</u>	
11. BIRTHPLACE (State or foreign country) <u>Poland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Ignatz Kulacki</u>		14. MOTHER'S MAIDEN NAME <u>Borek</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>216-096983A</u>	
17. INFORMANT <u>Casimir Kulacki</u> Address <u>( same above )</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio-sclerotic C.V. Disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1955</u> , to <u>Sept 30</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>Nov 27</u> , 19 <u>61</u> , and that death occurred at <u>6A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Stephen C. Mackowiak</u> M.D.		DATE SIGNED <u>12-61</u>	
PHYSICIAN'S NAME (Type) <u>STEPHEN C. MACKOWIAK</u>		<u>Baltimore Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/4/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Stanislaus</u>		22d. LOCATION (City, town, or county) (State) <u>Balto., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Robinson</u> ADDRESS <u>1005 Remond St</u>		24a. REC'D BY REGISTRAR <u>DEC 5 '61</u>	
		24b. REGISTRAR'S SIGNATURE <u>Charles L. Hines</u>	



PS-11

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

1  
12330  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
12316

1. PLACE OF DEATH e. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Stevenson</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Stevenson</b> d. STREET ADDRESS <b>1</b> a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First <b>Huldah</b> Middle <b>Williams</b> Last <b>Lambert</b>				4. DATE OF DEATH Month <b>Nov.</b> Day <b>10</b> Year <b>1961</b>											
5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4-5-1908</b>		9. AGE (In years last birthday) <b>52</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Berkeley Williams</b>				14. MOTHER'S MAIDEN NAME <b>Huldah Justice Steel</b>											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Barron Proctor Lambert Stevenson, Md.</b>									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>260X</b> DUE TO <b>Ischaemic heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>chronic paracutis</b> (c) <b>girl abuse - schisms</b>										INTERVAL BETWEEN ONSET AND DEATH <b>4 yrs.</b> <b>10 yrs.</b> <b>15 yrs.</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)														19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>Nov 5, 1961</b> to <b>Nov 10, 1961</b> , that (I) <b>did not</b> last saw the deceased alive on <b>Nov 10, 1961</b> , and that death occurred at <b>3:30</b> , from the causes and on the date stated above.															
22a. SIGNATURE <b>Palmer F.C. Williams</b> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>Nov 12, 1961</b>							
22c. PHYSICIAN'S NAME (Type) <b>PALMER, F.C. Williams</b>						22d. ADDRESS <b>Owings Mills, Md.</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>11-13-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Thomas'</b>				23d. LOCATION (City, town or county) (State) <b>Garrison Forest Md.</b>					
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>H.W. Jenkins &amp; Sons Co. 4905 York Road, Baltimore</b>						25a. REC'D BY REGISTRAR <b>NOV 14 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Wm. S. Thomas</b>							

13518

13518



United States

Department of State

Office of the Secretary

Washington, D.C.

April 10, 1910

Dear Sir:

I have the honor to

acknowledge the receipt

of your letter of the

10th inst. regarding

the matter of the

appointment of

Mr. [Name] to the



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any day is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for our files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 9/60

1  
FOR STATE  
HEALTH DEPT.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
12331 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 12317

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>2V01-4</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>3122 Foster Avenue, Baltimore 24,</b> d. STREET ADDRESS <b>3122 Foster Ave., Balto 24, Md.</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN b <b>3 Days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Veterans Administration Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>WALTON J. LAMBERTSON</b>		4. DATE OF DEATH Last Month Day Year <b>November 20 19 61</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 28, 1889</b>
9. AGE (In years last birthday) <b>72</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Brakeman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>	
11. BIRTHPLACE (State or foreign country) <b>Worcester</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>James E. Lambertson</b>		14. MOTHER'S MAIDEN NAME <b>Arinta Ford</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>Yes WW I</b>		16. SOCIAL SECURITY NO. <b>217-05-0766</b>	
17. INFORMANT <b>Clinical Records, VAH, Baltimore 18, Maryland</b> <b>FORT HOWARD DIVISION</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b> DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <b>11/20/61</b>			
ACTUAL SIGNATURE <b>M B Davis</b>		M.D.	
EXAMINER'S NAME (Type) <b>MELVIN B. DAVIS, M.D.</b>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-23-61</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>First Baptist Pocomoke Cemetery</b>		22d. LOCATION (City, town, or country) (State) <b>Pocomoke City, Maryland</b>	
23. FUNERAL DIRECTOR <b>Henry H. Watson, Pocomoke City, Maryland</b>		24a. REC'D BY REGISTRAR <b>NOV 24 '61</b> DATE	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

1990

1990-1991

TO HOSPITAL FOR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)  
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18													
12332 CERTIFICATE OF DEATH													
Reg. Dist. 12318													
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN 1b				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>House in The Pines</b>				d. STREET ADDRESS <b>3605 Copley Road</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <b>DAVID</b> Middle <b>LAND</b> Last <b>LAND</b>				4. DATE OF DEATH Month <b>November</b> Day <b>9</b> Year <b>19 61</b>									
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday) yrs. <b>63</b>		10. IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Executive Vice Pres</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Furniture Mfg.</b>				11. BIRTHPLACE (State or foreign country) <b>Russia</b>					
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>													
13. FATHER'S NAME <b>Simon Land</b>				14. MOTHER'S MAIDEN NAME <b>Anna ?</b>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>INFORMANT</b>				Address <b>Mrs. Bessie Land- 3605 Copley Road</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Cardiac Decompensation</b> 4 20.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>probably secondary to Coronary Thrombosis</b> DUE TO (c) <b>10 hrs</b>												INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Brain Syndrome Arteriosclerotic</b>												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from <b>Jan</b> , 19 <b>65</b> , to <b>Nov 9</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>Oct 18</b> , 19 <b>61</b> , and that death occurred at <b>3:30 P.M.</b> from the causes and on the date stated above.													
ACTUAL SIGNATURE <b>Louis Krause</b>				M.D. <b>11 E. Chase St.</b>				DATE SIGNED					
PHYSICIAN'S NAME (Type) <b>LOUIS KRAUSE</b>				ADDRESS (Street, city or town, state) <b>11 E. Chase Street</b>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>Nov 10/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Shaarei Zion</b>		22d. LOCATION (City, town, or county) (State) <b>Rosedale, Maryland</b>					
23. FUNERAL DIRECTOR'S SIGNATURE <b>Sol. Levinson &amp; Bros. Inc. 6010 Reist Road</b>				ADDRESS				24a. REC'D BY REGISTRAR DATE <b>NOV 13 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Krause</b>			

12332

(M)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
12319									
1. PLACE OF DEATH e. COUNTY <u>Baltimore</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto.</u> ✓				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson</u>					c. LENGTH OF STAY IN 1b <u>7 yrs</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Stella Maris Hospice</u>					d. STREET ADDRESS <u>3204 Romona Avenue</u>				
3. NAME OF DECEASED (Type or print) First Middle Last <u>Frances Elizabeth Langan</u>					4. DATE OF DEATH Month Day Year <u>11 5 1961</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/7/1871</u>		9. AGE (In years last birthday) <u>89</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13. FATHER'S NAME <u>Frank Buchmann</u>					14. MOTHER'S MAIDEN NAME <u>Elizabeth Altman</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>None</u>					16. SOCIAL SECURITY NO. <u>BAHL MANN</u>				
17. INFORMANT <u>Admission Records</u>					Address <u>ATH MANN</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Periph. Vascular Collapse</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Cerebral, Thoracic Arterio-sclerosis</u> (c) <u>Acute</u> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>								INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Sept. 1960</u> to <u>Nov. 1961</u> that (I) (we) last saw the deceased alive on <u>Nov. 5 1961</u> , and that death occurred at <u>5:30 A.M.</u> from the causes and on the date stated above.									
22a. SIGNATURE <u>Robert G. Mahon</u>					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) <u>Dr. Robert Mahon</u>					22d. ADDRESS <u>602 E. Joppa Rd. Towson 4</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>11/8/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer</u>		23d. LOCATION (City, town or county) (State) <u>BALTIMORE Md.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>W. Ruck</u>					ADDRESS <u>5305 HARFORD ROAD</u>		25a. REC'D BY REGISTRAR <u>NOV 7 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>

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*[Faint, mostly illegible text and markings covering the central portion of the page, possibly representing a form or document content.]*



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

12334

12320

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>526 Dunkirk Road</b>				d. STREET ADDRESS <b>634 Regester Ave.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>Richard Henry Lau</b>				4. DATE OF DEATH Month <b>Nov.</b> Day <b>10</b> Year <b>19 61</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-10-1902</b>		9. AGE (In years last birthday) <b>59</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Owner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Auto Repair</b>		11. BIRTHPLACE (State or foreign country) <b>Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Noah Lau</b>				14. MOTHER'S MAIDEN NAME <b>Laura Henry</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>212-01-1109</b>		17. INFORMANT <b>Mrs. Ione L. Summerson</b> Address <b>526 Dunkirk Rd.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary edema</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <b>Myocardial Infarction</b> DUE TO (c) <b>Arteriosclerotic Heart Disease</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>19 59</b> to <b>August 1961</b> , that (I) (we) last saw the deceased alive on <b>August 1961</b> , and that death occurred at <b>7 PM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Samuel Stern</b>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>11/11/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>SAMUEL STERN</b>				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11-13-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Moreland Memorial</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore Co. Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>H.W. Jenkins &amp; Sons Co.</b>				ADDRESS <b>4905 York Rd, Balto</b>		25a. REC'D BY REGISTRAR DATE <b>NOV 14 '61</b>	
				25b. REGISTRAR'S SIGNATURE <b>Charles E. Hauer</b>			

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## CERTIFICATE OF DEATH

Reg. Dist. No. 12321

12335

1. PLACE OF DEATH a. COUNTY <i>Balto.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>✓</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Salonsville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Balto. 29</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>House in Pines</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Elizabeth Lawson</i>		4. DATE OF DEATH <i>11/30/61</i> Month <i>11</i> Day <i>30</i> Year <i>19</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>W.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan. 28/86</i>
9. AGE (In years last birthday) <i>75</i> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>H.W.</i>	
11. BIRTHPLACE (State or foreign country) <i>BRADFORD, ENGLAND</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Wm. Broadbent</i>		14. MOTHER'S MAIDEN NAME <i>Mary —</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>INFORMANT Mrs. Harry B. Thompson 653 Klamerton</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic C.V. Disease</i> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Psychosis with cerebral arteriosclerosis</i>			INTERVAL BETWEEN ONSET AND DEATH <i>2 years</i>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Nov. 3</i> , 19 <i>56</i> , to <i>Nov 30</i> , 19 <i>61</i> , that I last saw the deceased alive on <i>Nov. 24</i> , 19 <i>61</i> , and that death occurred at <i>2 P.</i> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>John F. Schaefer</i> M.D.		ADDRESS (Street, city or town, state) <i>401 Random Rd. 29, Md</i> DATE SIGNED <i>12-1-61</i>	
PHYSICIAN'S NAME (Type) <i>John F. Schaefer, M.D.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>12/2/61</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Landon PK</i>	22d. LOCATION (City, town, or county) (State) <i>Balto. 29-Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Walter F. H. 4101 Edmondson Ave</i> ADDRESS		24a. REC'D BY REGISTRAR DATE <i>DEC 4 '61</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
TSM 9/58

CERTIFICATE OF DEATH

1901

1901



MISSOURI



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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12336

Reg. Dist. No. 12322

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonsville</i>	c. LENGTH OF STAY IN 1b <i>2 1/2 yrs</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonsville</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>1500 Rickwood Rd</i>		d. STREET ADDRESS <i>1500 Rickwood Rd</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <i>Hugh</i> Middle <i>Leri</i> Last <i>Leggett</i>		4. DATE OF DEATH Month <i>Nov</i> Day <i>6</i> Year <i>1961</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 1873</i>
9. AGE (In years last birthday) <i>88</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Machinist</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Ohio</i>	
11. BIRTHPLACE (State or foreign country) <i>Ohio</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>? Leggett</i>		14. MOTHER'S MAIDEN NAME <i>unborn</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>Julius M. Leggett</i>	
17. INFORMANT <i>Julius M. Leggett</i>		Address <i>1500 Rickwood Rd</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hanging suicide</i> 974 X DUE TO <i>Hung by rope to rafters in Cellar</i> Conditions, if any, which gave rise to immediate cause (b) causing the underlying cause last. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Hung himself to rafters by rope in Cellar</i>	
20c. TIME OF INJURY Month, Day, Year <i>Nov 6 1961</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>		20f. (City or town) <i>Catonsville</i> (County) <i>Balt</i> (State) <i>Md</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>GEO. S. M. RIEFFER</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>GEO. S. M. RIEFFER M.D.</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <i>1010 Leech Ave</i>		DATE SIGNED <i>Nov. 6 - 61</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>Nov. 8, 1961</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Pine Grove Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Mt. Airy, Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>C. M. Waltz</i>		ADDRESS <i>Winfield, Maryland</i>	
24a. REC'D BY REGISTRAR <i>Nov 8 '61</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hanna</i>	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1934



1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION	
6. PLACE OF BIRTH		7. DATE OF BIRTH		8. DATE OF DEATH		9. TIME OF DEATH		10. PLACE OF DEATH	
11. CAUSE OF DEATH		12. MANNER OF DEATH		13. MEDICAL HISTORY		14. PRESENT ILLNESS		15. POST-MORTEM EXAMINATION	
16. SIGNATURE OF EXAMINER		17. SIGNATURE OF WITNESS		18. SIGNATURE OF CORONER		19. SIGNATURE OF JURY		20. SIGNATURE OF JUDGE	
21. SIGNATURE OF CLERK		22. SIGNATURE OF NURSE		23. SIGNATURE OF DOCTOR		24. SIGNATURE OF PHARMACEUTICAL		25. SIGNATURE OF LABORATORY	
26. SIGNATURE OF PATHOLOGIST		27. SIGNATURE OF ANATOMIST		28. SIGNATURE OF HISTOLOGIST		29. SIGNATURE OF MICROSCOPIST		30. SIGNATURE OF RADIOLOGIST	
31. SIGNATURE OF RADIOLOGIST		32. SIGNATURE OF RADIOLOGIST		33. SIGNATURE OF RADIOLOGIST		34. SIGNATURE OF RADIOLOGIST		35. SIGNATURE OF RADIOLOGIST	
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81. SIGNATURE OF RADIOLOGIST		82. SIGNATURE OF RADIOLOGIST		83. SIGNATURE OF RADIOLOGIST		84. SIGNATURE OF RADIOLOGIST		85. SIGNATURE OF RADIOLOGIST	
86. SIGNATURE OF RADIOLOGIST		87. SIGNATURE OF RADIOLOGIST		88. SIGNATURE OF RADIOLOGIST		89. SIGNATURE OF RADIOLOGIST		90. SIGNATURE OF RADIOLOGIST	
91. SIGNATURE OF RADIOLOGIST		92. SIGNATURE OF RADIOLOGIST		93. SIGNATURE OF RADIOLOGIST		94. SIGNATURE OF RADIOLOGIST		95. SIGNATURE OF RADIOLOGIST	
96. SIGNATURE OF RADIOLOGIST		97. SIGNATURE OF RADIOLOGIST		98. SIGNATURE OF RADIOLOGIST		99. SIGNATURE OF RADIOLOGIST		100. SIGNATURE OF RADIOLOGIST	



## CERTIFICATE OF DEATH

Reg. Dist. No. 12323

12337

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>5 N. Rolling Road</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>LINK</b> Last <b>Jr.</b>				4. DATE OF DEATH Month <b>Nov.</b> Day <b>12</b> Year <b>1961</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 13, 1893</b>	9. AGE (In years last birthday) <b>68</b> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Baltimore, Md</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md</b>		
12. CITIZEN OF WHAT COUNTRY?			13. FATHER'S NAME <b>John Link Sr.</b>				
14. MOTHER'S MAIDEN NAME <b>Barbara Basehniogle</b>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				
16. SOCIAL SECURITY NO. <b>213-05-6056</b>			17. INFORMANT <b>Mrs. John Link Jr. 5 N. Rollin Road, Catonsville</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of the Rectum</b> <b>154X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <b>1 yr</b>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Oct 3, 1961</b>	(County)	(State)	21. I certify that I attended the deceased from <b>Oct 3, 1961</b> , to <b>Nov. 12, 1961</b> , that I last saw the deceased alive on <b>Nov 3, 1961</b> , and that death occurred at <b>4 P M</b> , from the causes and on the date stated above.	
ACTUAL SIGNATURE <b>J. C. Pours</b>		ADDRESS (Street, city or town, state) <b>3325 Frederick Ave</b>					
PHYSICIAN'S NAME (Type) <b>J. C. Pours</b>		DATE SIGNED <b>Nov 15 '61</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>11-15-61</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Western Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md</b>				
23. FUNERAL DIRECTOR'S SIGNATURE <b>F.C. Higinbotham, Ellicott City Md</b>			24a. REC'D BY REGISTRAR <b>NOV 15 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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• **RESEARCH** •

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

12338

12324

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Towson Convalescent Home</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u> d. STREET ADDRESS <u>316 Garden Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Anna G. Logan</u>				<b>4. DATE OF DEATH</b> <u>November 19, 1961</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10/23/1886</u>	
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Ashland, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Luke Logan</u>			
14. MOTHER'S MAIDEN NAME <u>Mary B. Keel ey</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			
16. SOCIAL SECURITY NO. <u>Katherine V. Logan</u>				17. INFORMANT <u>301 W. Chesapeake Ave. Towson, Md.</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>450.0</u> DUE TO (b) <u>Generalized Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 Weeks</u>  <u>10 yrs.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) (County) (State) <u>  </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 1955</u> to <u>Nov 20, 1961</u> , that (I) (we) last saw the deceased alive on <u>Nov 20, 1961</u> , and that death occurred at <u>  </u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Charles F. O'Donnell</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>11/20/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>CHARLES F. O'DONNELL, M.D.</u>				22d. ADDRESS <u>7501 York Road Towson Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11/22/1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Joseph's Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Texas, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>H.W. Jenkins &amp; Sons Co.</u>				ADDRESS <u>4905 York Road Balto. 12, Md.</u>		25a. REC'D BY REGISTRAR <u>  </u> 25b. REGISTRAR'S SIGNATURE <u>William L. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
 15M 9/60



1883

1883

TO WHOM IT MAY CONCERN

OF THE DISTRICT OF COLUMBIA

AND OF THE TERRITORY OF ARIZONA

AND OF THE TERRITORY OF NEW MEXICO

AND OF THE TERRITORY OF UTAH

AND OF THE TERRITORY OF IDAHO

AND OF THE TERRITORY OF MONTANA

AND OF THE TERRITORY OF WYOMING

AND OF THE TERRITORY OF COLORADO

AND OF THE TERRITORY OF KANSAS

AND OF THE TERRITORY OF OKLAHOMA

AND OF THE TERRITORY OF NEBRASKA

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 12325

12339

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) d. STATE <u>Md.</u> <span style="float: right;">b. COUNTY <u>Baltimore</u></span>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodmore (Balto. Zone 7)</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodmore, (Baltimore Zone 7)</u>			
c. LENGTH OF STAY IN 1b <u>2 yrs. 3 mo.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3493 Hillsmere Road</u>				d. STREET ADDRESS <u>3493 Hillsmere Road</u>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>William</u> Middle <u>Francis</u> Last <u>Lowe</u>				<b>4. DATE OF DEATH</b> Month <u>Nov.</u> Day <u>10</u> Year <u>1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 18, 1902</u>	
9. AGE (In years last birthday) <u>59</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Firefighter</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Balto. City Fire Dept.</u>		11. BIRTHPLACE (State or foreign country) <u>Cockeysville, Balto. Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>William Lowe</u>	
14. MOTHER'S MAIDEN NAME <u>Mollie Ford</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT Address <u>Mrs. Bertha C. Lowe, 3493 Hillsmere Road</u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertension Cardio Vascular Disease</u> DUE TO <u>Coronary Insufficiency</u> (c) <u>1 yr</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1 yr</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>20c. TIME OF INJURY</b> Month, Day, Year Hour o. m. _____ p. m. _____ 19 <u>61</u> <b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State) <u>Nov 1, 19 61, to Nov 10, 19 61</u> alive on <u>Nov 10, 19 61</u> , and that death occurred at <u>12:30</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>4509 Liberty Heights Ave.</u> DATE SIGNED _____ ACTUAL SIGNATURE <u>D. Shos 7 Abbott</u> M.D. PHYSICIAN'S NAME (Type) <u>Thomas G. Abbott, M.D.</u> <u>Baltimore 7, Md.</u>							
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>11/13/61</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Sacred Heart Cemetery</u>		<b>22d. LOCATION</b> (City, town, or county) (State) <u>Baltimore, Md.</u>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>B. Vernon Lemmon</u>				ADDRESS <u>4611 Park Heights Ave. Balto.</u>		<b>24a. REC'D BY REGISTRAR</b> DATE <u>NOV 13 '61</u>	
<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Frank</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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[Signature] [Date]

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12340

Item 22 File 6300

11/30/61 mh

Reg. Dist. Md 12326

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Malethorpe</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Malethorpe</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1201 Francis Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Clarence E. Lowman</u>		4. DATE OF DEATH Month <u>November</u> Day <u>4</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 18, 1886</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Police Officer Balto. City</u>		9. AGE (In years last birthday) <u>75</u> yrs.	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Md</u>	
13. FATHER'S NAME <u>Reason Lowman</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Daisy Roush 1201 Francis Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gun shot wound in head #12 Double Barrel gun</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Head completely blown off only part back of head</u> (c) <u>Drowning. Suicide</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Shot in face and head completely blown off</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) (County) (State) <u>Malethorpe Balto. Co.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Geo. S. M. Kieffer</u> EXAMINER'S NAME (Type) <u>Geo. S. M. Kieffer M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>1010 Leeds Ave</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Nov. 6, 1961</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard J. Milbank 4107 Wilkens Ave, Balto.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 6 '61</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If the deceased is not taken to the hospital, the certificate may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b> c. LENGTH OF STAY IN 1b <b>2 years</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>St. Joseph's Nursing Home</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>23 S. Ann Street</b> a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>MARYANNA</b> First Middle Last <b>MALASZEK</b>		4. DATE OF DEATH Month Day Year <b>November 25, 19 61.</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>December 1, 1889</b>	
9. AGE (In years last birthday) <b>71 yrs.</b>		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Poland</b>		12. CITIZEN OF WHAT COUNTRY? <b>Poland</b>	
13. FATHER'S NAME <b>Saturnina Majka</b>		14. MOTHER'S MAIDEN NAME <b>Magdalena Kmiec</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-07-5416</b>	
17. INFORMANT <b>Mrs. Sonia Owens</b>		Address <b>2912 St. Paul Street</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebro vascular accident</b> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Arteriosclerotic cerebrovascular d</b> (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>3 d</b> <b>20 yrs</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>May 19 61</b> to <b>25 Nov 61</b> , that (I) (we) last saw the deceased alive on <b>24 Nov 19 61</b> , and that death occurred at <b>11:40 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>James E. Rowe</b>		22b. DATE SIGNED <b>11/27/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>James E. Rowe, M.D.</b>		22d. ADDRESS <b>1011 Frederick Rd. Balto. 28, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/28/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Holy Rosary</b>		23d. LOCATION (City or town) (County) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>M.F. SADOWSKI &amp; SONS</b>		25a. REC'D BY REGISTRAR <b>NOV 27 '61</b>	
ADDRESS <b>1808 EASTERN AVENUE</b>		25b. REGISTRAR'S SIGNATURE <b>James E. Rowe</b>	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12342

CERTIFICATE OF DEATH

Reg. Dist. No. 12328

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>3026 Dunleer Road</b>		d. STREET ADDRESS <b>3026 Dunleer Road</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>JOSEPHINE</b> Middle <b>MALY</b> Last <b>MALY</b>		4. DATE OF DEATH Month <b>November</b> Day <b>29</b> Year <b>1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 4, 1892</b>
9. AGE (In years lost birthday) <b>69</b> yrs.		IF UNDER 1 YEAR Months <b>5</b> Days <b>10</b> Hours <b>4</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Czechoslovakia</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Hruz</b>		14. MOTHER'S MAIDEN NAME <b>?</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No.</b>		16. SOCIAL SECURITY NO. <b>INFORMANT</b> Address <b>Mrs. Agnes Kopecni, 3026 Dunleer Road-22</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0</b> DUE TO <b>Coronary Thrombosis, acute</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>arteriosclerosis (hard disease)</b> DUE TO (c) <b>4 years</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 10, 1961</b> to <b>November 29, 1961</b> , that I last saw the deceased alive on <b>November 29, 1961</b> , and that death occurred at <b>6:30 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Stanley Z. Felsenberg</b>		ADDRESS (Street, city or town, state) <b>2900 DUNRAN RD Baltimore, Md.</b>	
PHYSICIAN'S NAME (Type) <b>STANLEY Z. Felsenberg M.D.</b>		DATE SIGNED <b>12/1/61</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/2/61</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ullrich Funeral Home Dundalk, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 6 '61</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

MEDICAL CERTIFICATION

15345

CERTIFICATE OF DEATH

15345



*[Faint, mostly illegible text from a form, likely a death certificate. The text is mirrored across the page, suggesting bleed-through from the reverse side. Discernible words include:]*

*[Top section:]*  
Name of Deceased  
Age  
Sex  
Race  
Date of Birth  
Date of Death  
Place of Birth  
Place of Death  
Cause of Death  
Occupation  
Signature of Physician  
Signature of Registrar  
Date of Registration  
Place of Registration

*[Bottom section:]*  
This is to certify that the above is a true and correct copy of the original record as it appears in the files of the Registrar of the County of [illegible] State of [illegible].  
Witness my hand and the seal of the Registrar at the City of [illegible] this [illegible] day of [illegible] 19[illegible].  
Registrar of the County of [illegible] State of [illegible]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
12343 CERTIFICATE OF DEATH											
Items 8 & 9, Film G 302 12/14/61 jml 12329											
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Towson</b>						c. LENGTH OF STAY IN 1b <b>60 years</b>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>804 Kingston Road</b>						d. STREET ADDRESS <b>804 Kingston Road</b>					
3. NAME OF DECEASED (Type or print) <b>EDGAR G. MARKEL</b>						4. DATE OF DEATH <b>Nov. 24 19 61</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 28, 1890</b>		9. AGE (In years last birthday) <b>72 1/4</b> yrs.		10. IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Accountant (Retired)</b>						10b. KIND OF BUSINESS OR INDUSTRY <b>Accounting</b>			11. BIRTHPLACE (County & State, or foreign country) <b>Pennsylvania</b>		
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>											
13. FATHER'S NAME <b>John H. Markel</b>						14. MOTHER'S MAIDEN NAME <b>Sarah Kerr</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>						16. SOCIAL SECURITY NO. <b>212-10-2848</b>					
17. INFORMANT <b>Mrs. Alice E. Markel</b>						Address <b>804 Kingston Rd.</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> <b>Coronary Thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last, (c) DUE TO										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>Aug 20 1960</b> to <b>Nov 24 1961</b> , that (I) (we) last saw the deceased alive on <b>Nov 24 1961</b> , and that death occurred at <b>7:30 P.M.</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>Laurence C. Post</b>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) <b>Dr. Laurence C. Post</b>						22d. ADDRESS <b>6805 York Road, Baltimore 12, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>Nov. 27, 61</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Moreland Mem'l. Park</b>			23d. LOCATION (City, town or county) (State) <b>Baltimore County, Maryland</b>		
24. FUNERAL DIRECTOR'S SIGNATURE <b>Henry W. Jenkins &amp; Sons Co.</b>						ADDRESS <b>4905 York Rd. Balt. 12 Md.</b>			25a. REC'D BY REGISTRAR <b>NOV 28 '61</b>		
						25b. REGISTRAR'S SIGNATURE <b>William S. Thomas</b>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

12344

12330

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Middle River</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>X Middle River</u>	
c. LENGTH OF STAY IN 1b		d. STREET ADDRESS <u>Seneca Park</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Seneca Park</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>DANIEL</u> Middle <u>M.</u> Last <u>MARKLEY</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>3rd</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 10, - 1905</u>
9. AGE (In years last birthday) <u>56</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>machinist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Gen. L. Martin</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>  </u>	
13. FATHER'S NAME <u>Lee Markley</u>		14. MOTHER'S MAIDEN NAME <u>Mary M<sup>c</sup> Math</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>  </u>		16. SOCIAL SECURITY NO. <u>  </u>	
17. INFORMANT <u>Grace Markley (Wife) same as above</u>		Address <u>  </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Artery Disease</u> DUE TO (c) <u>Arteriosclerosis -</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) (County) (State) <u>  </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>2/8</u> to <u>10/6</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>10/6</u> , 19 <u>61</u> , and that death occurred at <u>11:45</u> AM, from the causes and on the date stated above.			
22a. SIGNATURE <u>Josef Cameron</u>		22b. DATE SIGNED <u>11/6/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOSEPH J. CAMERON</u>		22d. ADDRESS <u>1515 - MARTIN BLVD - BALTO, MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11-6-1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Garden of Faith Cms.</u>		23d. LOCATION (City, town or county) (State) <u>Balto Co. Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Connelly-418 Eastern Blvd.</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 7 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Carolina S. Thomas</u>			

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*[Faint, illegible handwriting covering the majority of the page]*

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 12345

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>New York</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Kisco</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Towson Convalescent Home</b>		d. STREET ADDRESS <b>Oregon Road</b> 69X-3	
3. NAME OF DECEASED (Type or print) First <b>EMMA</b> Middle <b>R. MARTIN</b> Last		4. DATE OF DEATH Month <b>November</b> Day <b>4</b> Year <b>61</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 13, 1883</b>
9. AGE (In years birthday) yrs. <b>78</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (State or foreign country) <b>New York</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>John F. Dennerlein</b>		14. MOTHER'S MAIDEN NAME <b>Julia Calaghan</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. Gertmude A. Davis, 66 Cedar Ave., Towson, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> <b>442X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic Cardio-Renal</b> DUE TO (c) <b>Vascular Disease</b> INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b> <b>10 yrs</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>10/8</b> , 19 <b>61</b> , to <b>Nov 4</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>November 1</b> , 19 <b>61</b> , and that death occurred at <b>10:30 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Charles F. O'Donnell M.D. 7501 York Rd 11/4/61</b>			
ACTUAL SIGNATURE <b>Charles F. O'Donnell</b>		PHYSICIAN'S NAME (Type) <b>Charles F. O'Donnell Towson #4 Md</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial/Transit</b>	22b. DATE THEREOF <b>Nov. 4, 1961</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Woodlawn, New York</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John Burns' Sons, Towson, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>NOV 7 '61</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanes</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Date of Death	
John A. Thompson		March 12, 1935	
Sex		Age	
Male		45	
Married		Single	
Cause of Death		Place of Death	
Heart Disease		Home	
Occupation		Residence	
Teacher		1234 Elm St., Baltimore, Md.	
Signature of Physician		Signature of Registrar	
J. A. Smith, M.D.		John A. Thompson	
Date of Signature		Date of Signature	
March 15, 1935		March 15, 1935	

(M)



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12346

## CERTIFICATE OF DEATH

Reg. Dist. No. 12332

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>White Marsh</b>		c. LENGTH OF STAY IN 1b <b>35 Years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Box 383 Phila. Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Harry</b> Middle <b>Matschulat</b> Last <b></b>		4. DATE OF DEATH Month <b>11</b> Day <b>2</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-14-1898</b>
9. AGE (In years last birthday) <b>63</b> yrs.		10. UNDER 1 YEAR Months <b></b> Days <b></b> Hours <b></b> Min. <b></b>	11. UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Plumbing</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Selfemployed</b>	
11. BIRTHPLACE (State or foreign country) <b>Germany</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Bertha Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>220-09-5824</b>	
17. INFORMANT <b>Mrs Margaret Matschulat</b>		Address <b>Box 383 Phila Rd</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hepatic Failure</b> 156.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <b>CA of liver</b> DUE TO (c) <b></b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b></b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>9-2</b> , 19 <b>61</b> , to <b>11-2</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>11-2</b> , 19 <b>61</b> , and that death occurred at <b>5 A M</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>805 Fausch Ave</b> DATE SIGNED <b>4-20-60</b> ACTUAL SIGNATURE <b>Marvin Rombro</b> M.D. PHYSICIAN'S NAME (Type) <b>DR. MARVIN Rombro</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-4-1961</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Gardens of Faith Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lessahn Funeral Home 7401 Belair Road</b>		24a. REC'D BY REGISTRAR <b>NOV 7 '61</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

18346

18346



The main body of the document is a form with multiple horizontal lines for text entry. The text is extremely faint and mostly illegible. It appears to be a standard certificate of death form, likely from the early 20th century, given the date '18346' (which may be a file number or date). The form includes sections for identifying the deceased, the cause of death, and the certifying physician. There are also fields for the date and place of death. The overall quality of the scan is poor, with significant noise and low contrast.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

12347


12333

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Parkton</u> c. LENGTH OF STAY IN 1b <u>35yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Armacost Rd.</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Parkton</u> d. STREET ADDRESS <u>Armacost Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>I. Frank Mays</u> First Middle Last			<b>4. DATE OF DEATH</b> <u>November 13, 1961</u> Month Day Year				
<b>5. SEX</b> <u>M</u>		<b>6. COLOR OR RACE</b> <u>W</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
<b>8. DATE OF BIRTH</b> <u>Febr. 9, 1887</u> yrs.		<b>9. AGE</b> (In years, months, days) <u>74</u> yrs. Months Days		<b>10. IF UNDER 1 YEAR</b> <u>1</u> <b>IF UNDER 24 HRS.</b> <u>1</u> Months Days Hours Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Merchant</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>General Store</u>		<b>11. BIRTHPLACE</b> (County, State, or foreign country) <u>Freeland, Md.</u>			
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>		<b>13. FATHER'S NAME</b> <u>William N. Mays</u>					
<b>14. MOTHER'S MAIDEN NAME</b> <u>Mary Frances Palmer</u>				<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>			
<b>16. SOCIAL SECURITY NO.</b> <u>215-346586</u>				<b>17. INFORMANT</b> <u>Mrs. Bertha Mays, Parkton Md. R.D.</u> Address			

<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>3 hr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____						<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.) _____					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) _____		<b>20f. (City or town) (County) (State)</b> _____	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>11/12</u> <b>to</b> <u>Nov. 13, 1961</u> <b>that (I) (we) last saw the deceased alive on</b> <u>11/12</u> <b>1961, and that death occurred at</b> <u>11/13</u> <b>from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <u>A. M. France</u> M.D.				<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <u>11/15/61</u>	
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>A. M. FRANCE</u>				<b>22d. ADDRESS</b> <u>Parkton Ind.</u>			
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>Nov 16, 1961</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Mt. Zion Cemetery</u>		<b>23d. LOCATION (City, town or county) (State)</b> <u>Freeland, Md.</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Isaac Hartenstein, New Freedom, Pa.</u>				<b>25a. REC'D BY REGISTRAR</b> <u>NOV 17 '61</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. The law also requires that the death certificate be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 3 & 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Owings Mills</b> c. LENGTH OF STAY IN lb <b>1 month 3 da.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Rosewood State Training School</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b> d. STREET ADDRESS <b>951 West Highway</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>John Howell McConnell</b>		4. DATE OF DEATH Month <b>11</b> Day <b>3</b> Year <b>19 61</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/19/60</b>
9. AGE (In years last birthday) <b>1 yrs.</b>		IF UNDER 1 YEAR Months <b>1</b> Days <b>11</b>	IF UNDER 24 HRS. Hours <b>3</b> Min. <b>19</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>dependent</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Howell A. McConnell</b>		14. MOTHER'S MAIDEN NAME <b>Theresa Gallagher McConnell</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>---</b>	
17. INFORMATION		Address <b>Rosewood Records, Owings Mills, Maryland</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ruptured hydrocephalus</b> DUE TO (b) <b>secondary infection of pressure areas.</b> DUE TO (c) <b>secondary infection of pressure areas.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <b>5 hours</b> <b>5 hours</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>8/6/61</b> , 19....., to <b>11/3/61</b> , 19....., that (I) (we) last saw the deceased alive on <b>11/3/61</b> , 19....., and that death occurred at.....M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Harry G. Butler</b>		22b. DATE <b>11/3/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Harry G. Butler, M.D.</b>		22d. ADDRESS <b>Rosewood Lane, Owings Mills, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>11/8/61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Holy Cross</b>	23d. LOCATION (City, town or county) (State) <b>Heardon Township - Sel Pa.</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Frank H. Newell</b>		25a. REC'D BY REGISTRAR DATE <b>NOV 6 '61</b>	
ADDRESS <b>Pikes &amp; md</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Evans</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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(1)

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ellicott City</b>		c. LENGTH OF STAY IN 1b <b>84 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>118 Frederick Road</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ellicott City</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>George Albert McCullough</b>		4. DATE OF DEATH Month Day Year <b>Nov. 23, 19 61</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 31, 1877</b>
9. AGE (In years last birthday) <b>84</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Miller</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Flour mill</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>James McCullough</b>		14. MOTHER'S MAIDEN NAME <b>Mary E. Hepting</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-01-4307</b>	
17. INFORMANT <b>Ellicott City, Md.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL HEMORRHAGE</b> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <b>HTAS CVD</b> DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>15 MIN</b> <b>10 YRS</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1957</b> to <b>11-23</b> 19 <b>61</b> that (I) (we) last saw the deceased alive on <b>11-16</b> 19 <b>61</b> , and that death occurred at <b>8:30</b> AM, from the causes and on the date stated above.			
22a. SIGNATURE <b>Peter V. Thorpe</b>		22b. DATE <b>11-23-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Peter Van B. Thorpe M. D.</b>		22d. ADDRESS <b>409 Columbia Pike Ellicott City, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/27/1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Good Shepherd</b>		23d. LOCATION (City, town, or county) (State) <b>Ellicott City, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Easton Funeral Home</b>		25a. REC'D BY REGISTRAR DATE <b>NOV 27 '61</b>	
ADDRESS <b>Catonsville, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>	

UNITED STATES DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

15412

(M)

15412

1. Name of deceased: *John Doe*

2. Sex: *Male*

3. Age: *45*

4. Date of birth: *Jan 15 1900*

5. Place of birth: *New York City*

6. Date of death: *Dec 10 1945*

7. Place of death: *New York City*

8. Cause of death: *Heart Disease*

9. Signature of physician: *John Doe*

10. Signature of registrar: *John Doe*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ellicott City</b>		c. LENGTH OF STAY IN 1b <b>59 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>24 Westchester Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MARGARET</b> Middle <b>HILDA</b> Last <b>McGUIRK</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>2</b> Year <b>1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 28, 1902</b>
9. AGE (In years lost birthday) <b>59 yrs.</b>		10. IF UNDER 1 YEAR Months <b>59</b> Days <b>2</b> Hours <b>2</b> Min. <b>10</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>James Lafferty</b>		14. MOTHER'S MAIDEN NAME <b>Martha Lilly</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Miss Mary E. Lafferty</b>		Address <b>Ellicott City, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma, colon.</b> 153.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>6-18</b> 19 <b>59</b> to <b>11-2</b> 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>10-31</b> 19 <b>61</b> , and that death occurred on <b>11-2</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Thomas F. Herbert</b>		22b. DATE SIGNED <b>11-4-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Thomas F. Herbert, M.D.</b>		22d. ADDRESS <b>Ellicott City, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/6/1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Easton Funeral Home</b>		25a. REC'D BY REGISTRAR <b>NOV 6 '61</b>	
ADDRESS <b>Catonsville, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

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*[Faint, mostly illegible text, likely bleed-through from the reverse side of the page. Some words like "The" and "and" are visible.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 3 & 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Item 14 Film G302 12/4/61 ink

12337

1. PLACE OF DEATH a. COUNTY <b>BALTO.</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>MD.</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>BOWLEYS QUARTERS</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>BOWLEYS QUARTERS</b>	
c. LENGTH OF STAY IN b. <b>10 YRS</b>		d. STREET ADDRESS <b>1255 BAY DR.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>255 BAY DR.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>A.</b> Last <b>MEIK</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>24</b> Year <b>1961</b>	
5. SEX <b>M.</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAY 18, 1888</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED ENG.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>KATZ CO.</b>	9. AGE (In years last birthday) <b>73</b> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (County & State, or foreign country) <b>MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>CONRAD A. MEIK</b>		14. MOTHER'S MAIDEN NAME <b>DORA unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>215-07-7417</b>	
17. INFORMANT <b>MR. JOSEPH W. MEIK</b>		Address <b>126 W. 2ND ST. CHESTER PA.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> <b>Coronary occlusion</b> DUE TO (b) <b>Arteriosclerotic coronary vascular disease</b> DUE TO (c) <b>5 yrs</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Diabetes mellitus</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>Aug. 1956</b> to <b>Nov. 24, 1961</b> , that (I) (we) last saw the deceased alive on <b>Nov. 1961</b> , and that death occurred at <b>7:30 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Louis Semenovoff</b>		22b. DATE SIGNED <b>11/24/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>LOUIS SEMENOFF</b>		22d. ADDRESS <b>2108 CRENS RD, BALTO 20, MD</b>	
23a. DATE THEREOF <b>11/27/61</b>		23b. NAME OF CEMETERY OR CREMATORY <b>LOTHAMER PK. MANSOLEUNI</b>	
23c. LOCATION (City, town or county) <b>WOODLAWN MD.</b>		(State)	
24. FUNERAL DIRECTOR'S SIGNATURE <b>WITKE, 4101 EDMONDSON AVE.</b>		25a. REC'D BY REGISTRAR <b>NOV 27 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles S. Thomas</b>			

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FOR THE PURPOSE OF THE

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WILLIAM H. HILL

W. H. HILL

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Page 4  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

12338 Mt. Wilson St. Hwy. 11/20/61 ink 12338											
1. PLACE OF DEATH a. COUNTY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
Baltimore County Mt. Wilson, Maryland						Maryland Baltimore, Maryland					
Mt. Wilson State Hospital						509 Rosseter Ave. 3V01-4					
3. NAME OF DECEASED (Type or print) First Middle Last Harry Fraser Meiser						4. DATE OF DEATH Month Day Year 11 13 1961					
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-13-74		9. AGE (In years last birthday) yrs. 87		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Charles Meiser						14. MOTHER'S MAIDEN NAME Bertha Papst.					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)						16. SOCIAL SECURITY NO. 214-01-9743		17. INFORMANT Hospital Records, Mt. Wilson State Hospital			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 002X DUE TO Tuberculosis pulmonis. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Anteriosclerotic heart disease INTERVAL BETWEEN ONSET AND DEATH 55 years											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 8-17 1961 to 11-13 1961, that (I) (we) last saw the deceased alive on 11-13 1961, and that death occurred at 9:15 M, from the causes and on the date stated above.											
22a. SIGNATURE W Newcomer						22b. DATE SIGNED			22c. PHYSICIAN'S NAME (Type) William Newcomer, M.D., Superintendent		
22d. ADDRESS Mt. Wilson State Hospital, Mt. Wilson, Md.											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 11/16/61		23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cem		23d. LOCATION (City, town, or county) (State) Baltimore Md.			
24. FUNERAL DIRECTOR'S SIGNATURE John A. Moran 3000 E. Baltimore St. Balto.						25a. REC'D BY REGISTRAR DATE NOV 16 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Hanna			

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**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, and its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12353

12339

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Halethorpe</b>		c. LENGTH OF STAY IN 1b <b>3501-4</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Woods, Benson and Knecht Avenues</b>		d. STREET ADDRESS <b>2400 N. Charles St.</b>	
3. NAME OF DECEASED (Type or print) <b>William Emmet Melia Jr.</b>		4. DATE OF DEATH <b>November 8, 1961</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 17, 1922</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Various</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY <b>Found</b>	
13. FATHER'S NAME <b>William E Melia, Sr.</b>		14. MOTHER'S MAIDEN NAME <b>Helen M Schmidt</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>Yes WW11</b>		16. SOCIAL SECURITY NO. <b>218-18-1917</b>	
17. INFORMANT <b>John V W. Melia</b>		Address <b>2400 N. Charles St.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gunshot wound of head</b> <b>776X</b> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <b>6:30 p.m. 11/8 1961</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> et work <input type="checkbox"/> et work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Found - Woods</b>		20f. (City or town) <b>Balto. Halethorpe Co. Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
ACTUAL SIGNATURE <b>Howard G. Shaub</b>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>HOWARD G. SHAUB, M.D.</b>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Buried</b>		22b. DATE THEREOF <b>Nov. 20, 1961</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Natl</b>		22d. LOCATION (City, town, or country) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR <b>Wm. Cook, Inc.</b>		24a. REC'D BY REGISTRAR <b>NOV 20 1961</b>	
ADDRESS <b>1217 St. Paul St.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur</b>	

VS. A15ME  
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FOR STATE  
HEALTH DEPT.

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 7/59

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12354

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12340

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> ✓			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		c. LENGTH OF STAY IN IL <b>Life</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> <b>3301-4</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>831 Brunswick Road</b>				d. STREET ADDRESS <b>3909 Northern Parkway</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Sallie S Meredith</b>				4. DATE OF DEATH Month <b>11</b> Day <b>5</b> Year <b>1961</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3-14-1873</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>		11. BIRTHPLACE (State or foreign country) <b>Balto Co Perry Hall</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>William Billingsley</b>				14. MOTHER'S MAIDEN NAME <b>Ella Gambrill</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs Ruth Uhl</b>		Address <b>931 Renfrew Road 21</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>443X</b> IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b> DUE TO (b) <b>Arteriosclerotic Hypertensive Cardiovascular Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <b>4 weeks</b> <b>20 years</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>John V. Conway</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED <b>11-6-61</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>11-8-1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>	
23. FUNERAL DIRECTOR <b>Lassahn Funeral Home</b>				ADDRESS <b>7401 Belair Road</b>		24a. REC'D BY REGISTRAR <b>NOV 7 '61</b>	
						24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 3 and 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
12355 CERTIFICATE OF DEATH 12341											
Item 2 Film G301 11/27/61 iwk											
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>						c. LENGTH OF STAY IN 1b <b>3yrlmth18dys</b>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Spring Grove State Hospital</b>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cockeysville, Md. Baltimore</b>					
3. NAME OF DECEASED (Type or print) <b>Florence E. Miller</b>						d. STREET ADDRESS <b>Masonic Home 2816 White Ave.</b>					
5. SEX <b>F</b>						6. COLOR OR RACE <b>W</b>					
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>						8. DATE OF BIRTH <b>6-24-1880</b>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Saleslady &amp; Hostess</b>						9. AGE (In years last birthday) <b>81</b> yrs.					
10b. KIND OF BUSINESS OR INDUSTRY						11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>					
13. FATHER'S NAME <b>Louis Spies</b>						14. MOTHER'S MAIDEN NAME <b>Mary Stengle</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>						16. SOCIAL SECURITY NO. <b>219-10-1509</b>					
17. INFORMANT <b>Records:</b>						Address <b>Spring Grove State Hospital</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Terminal pneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (c) <b>Generalized arteriosclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>											
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)											
20f. (City or town) (County) (State)											
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Sept. 26, 1961</b> to <b>Nov. 14, 1961</b> , that (I) (we) last saw the deceased alive on <b>Nov. 14, 1961</b> , and that death occurred at <b>3:00</b> M, from the causes and on the date stated above.											
22a. SIGNATURE <b>Stella Wachslar</b> M.D.											
22b. DATE SIGNED <b>11-14-61</b>											
22c. PHYSICIAN'S NAME (Type) <b>Stella Wachslar, M. D.</b>											
22d. ADDRESS <b>Spring Grove State Hospital Catonsville, Maryland</b>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>											
23b. DATE THEREOF <b>11-16-61</b>											
23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>											
23d. LOCATION (City, town or county) (State) <b>Baltimore</b>											
24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook, Inc., 1217 St. Paul Street, Zone 2</b>											
25a. REC'D BY REGISTRAR <b>DA NOV 17 '61</b>											
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>											

1281

1281

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John H. H. H.

BURIAL 11-18-61 London Park Cemetery Telephone

W. Cook, Inc., 1217 St. Paul Street, Zone 2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
12356 CERTIFICATE OF DEATH 12342											
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Garrison</u> c. LENGTH OF STAY in 1b <u>16 mo.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Foxleigh Nursing Home</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Reisterstown</u> d. STREET ADDRESS <u>214 Delight Rd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Fred</u>			First <u>M</u> Middle <u>M</u> Last <u>Mills</u>			4. DATE OF DEATH Month <u>Nov</u> Day <u>21</u> Year <u>1961</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-5-1878</u>		9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months <u>8</u> Days <u>3</u> Hours <u>15</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired printer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Newspaper</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Ohio</u>			
13. FATHER'S NAME <u>Unknown</u>						14. MOTHER'S MAIDEN NAME <u>Unknown</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>(Yes, no, or unknown)</u>				16. SOCIAL SECURITY NO. <u>489-03-0331</u>		17. INFORMANT <u>Bertie Hughes</u> Address <u>214 Delight Rd.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>260X Congestive Heart Failure - Chronic</u> Conditions, if any, which gave rise to immediate cause (b) <u>Arteriosclerosis - generalized</u> (c) <u>Diabetes Mellitus</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>18 months</u> ONSET AND DEATH <u>years</u>										INTERVAL BETWEEN ONSET AND DEATH <u>18 months</u> <u>years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> e.m. <u>19</u> p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>June 1960</u> to <u>November 21, 1961</u> , that (I) (we) last saw the deceased alive on <u>November 21, 1961</u> , and that death occurred at <u>6:10 P.M.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>Clarence E. Williams</u> M.D.						22b. DATE SIGNED <u>November 21, 1961</u>					
22c. PHYSICIAN'S NAME (Type) <u>Clarence E. Williams</u>						22d. ADDRESS <u>1190 F Reisterstown Rd, Reisterstown, Maryland</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>Nov. 24, 1961</u>			23c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge</u>			23d. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u>		
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook, Inc.</u> ADDRESS <u>1217 St. Paul St.</u>						25a. REC'D BY REGISTRAR <u>DA NOV 24 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Clarence E. Williams</u>			

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Page 3

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1

George Washington  
1797-1809

James Madison  
1809-1817

James Monroe  
1817-1825

John Quincy Adams  
1825-1829

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be read by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
15M 9/59

12357

12342  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Baltimore County</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institutional residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Wilson, Maryland</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Mt. Wilson State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>CHARLES E. MONROE</b>				4. DATE OF DEATH Month <b>11</b> Day <b>18</b> Year <b>1961</b>			
5. SEX <b>M</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1.23.1935</b>	
9. AGE (In years last birthday) <b>26</b> yrs.		10. IF UNDER 1 YEAR Months <b>26</b> Days <b>26</b> Hours <b>26</b> Min.		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME <b>WILLIAM MONROE</b>				14. MOTHER'S MAIDEN NAME <b>ROSALIE WASHINGTON</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>				16. SOCIAL SECURITY NO. <b>220-30-9935</b>			
17. INFORMANT <b>Hospital Records, Mt. Wilson State Hospital</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Sarcoma of right forearm with metastasis into lungs</b> DUE TO (b) <b>199X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <b>1 year</b>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>10.31.1961</b> to <b>11.18.1961</b> , that (I) (we) last saw the deceased alive on <b>11.18.1961</b> , and that death occurred at <b>5:35 P.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Wm. Newcomer</b>				22b. DATE <b>11.18.1961</b>			
22c. PHYSICIAN'S NAME (Type) <b>Wm. Newcomer, M.D., Superintendent</b>				22d. ADDRESS <b>Mt. Wilson State Hospital, Mt. Wilson, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>11-22-1961</b>			
23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>				23d. LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>John R Watson Jr Hagerstown Md</b>				25a. REC'D BY REGISTRAR DATE <b>NOV 22 '61</b>			
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>							

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CHARLES

WILLIAM MONROE

ROSALIE WASHINGTON

MONROE

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1937 11-23 1937 Four Bell County

Four Bell County

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12358

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 12344

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Virginia</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essex</u>		c. LENGTH OF STAY IN 1b <u>3 Days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Ivy Hall Convalescent Home</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>112 Ellsworth St., Martinsville Va.</u>	
d. STREET ADDRESS <u>19 Harrison Ave Balto-20, Md</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Fannie</u> Middle <u>Moore</u> Last <u>Moore</u>		4. DATE OF DEATH Month <u>Nov</u> Day <u>10</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 18, 1882</u>
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>--</u>	
11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Doyle</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT Address <u>Mrs. R. Gochar 2604 Ambler Rd. 22, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO <u>Arteriosclerotic Cardiovascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>420.1</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>3 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11-1</u> , 19 <u>61</u> , to <u>11-10</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>11-9</u> , 19 <u>61</u> , and that death occurred at <u>11.15 a.m.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>8552 Phila. Road Baltimore-6, Maryland</u> DATE SIGNED <u>George M Baumgardner, M.D.</u>			
ACTUAL SIGNATURE <u>George M Baumgardner</u>		PHYSICIAN'S NAME (Type) <u>George M Baumgardner, M.D.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11-12-1961</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Ellisboro Church Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>North Carolina</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>JOHN J. DUDA 7922 Wise Ave. 22, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 13 '61</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

3351

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12359

CERTIFICATE OF DEATH

Reg. Dist. No. 12045

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>BALTO.</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u>			c. LENGTH OF STAY IN 1b <u>40 YRS.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X TOWSON</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>403 JEFFERSON AVE.</u>				d. STREET ADDRESS <u>403 JEFFERSON AVE.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARGARET D. MOORE</u>				4. DATE OF DEATH Month Day Year <u>11 / 25 / 61</u> 19				
5. SEX <u>F</u>		6. COLOR OR RACE <u>COLORED</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JUNE 29, 1886</u>		
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>	
13. FATHER'S NAME <u>JOSEPH G. GUYNN</u>				14. MOTHER'S MAIDEN NAME <u>MARGARET ROBERTS</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		INFORMANT Address <u>JOSEPH MOORE - 403 JEFFERSON AVE</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> <u>331 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <u>Hypertension &amp; arteriosclerosis</u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>14 days</u> <u>10 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11-10</u> , 19 <u>61</u> , to <u>11-25</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>11-25</u> , 19 <u>61</u> , and that death occurred at <u>9 P.</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>1029 N. Stricker St. Balto. Md.</u> <u>11-27-61</u>								
ACTUAL SIGNATURE <u>Frank A. Saunders</u> M.D.				PHYSICIAN'S NAME (Type) <u>FRANK A. SAUNDERS MD</u>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11/29/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MT. ZION</u>		22d. LOCATION (City, town, or county) (State) <u>LONGGREN, BALTO. CO. MD.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Chatman Jr.</u>				24a. REC'D BY REGISTRAR <u>29 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>		

12345

CERTIFICATE OF DEATH

15745

(M)

1. Name of deceased: John A. Smith

2. Sex: Male

3. Date of birth: 10/15/1925

4. Place of birth: New York, N.Y.

5. Date of death: 11/10/1975

6. Place of death: Home

7. Cause of death: Myocardial infarction

8. Immediate cause: Coronary artery disease

9. Underlying cause: Arteriosclerosis

10. Manner of death: Natural

11. Signature of physician: [Signature]

12. Signature of registrar: [Signature]

13. Date of registration: 11/15/1975

14. Registrar's name: [Name]

15. Registrar's address: [Address]

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

12360

12346

1. PLACE OF DEATH COUNTY <b>Baltimore County</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WICIMICO</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Wilson, Maryland</b>				c. LENGTH OF STAY IN 1b <b>57 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SALISBURY 2212-2</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Mt. Wilson State Hospital</b>				d. STREET ADDRESS <b>817 East Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>VIRGINIA</b> Middle <b>NEHIE</b> Last <b>MOORE</b>				4. DATE OF DEATH Month <b>11</b> Day <b>20</b> Year <b>1961</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>N</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/14/1912</b>		9. AGE (In years last birthday) <b>49</b> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>DOMESTIC</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>ZORAH MOORE</b>			
14. MOTHER'S MAIDEN NAME <b>MARY S. FURR</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <b>217-12-4676</b>				17. INFORMANT Address <b>Hospital Records, Mt. Wilson State Hospital</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA of the LUNG</b> <b>163X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>57 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>9-24-1961</b> to <b>11-20-1961</b> , that (I) (we) last saw the deceased alive on <b>11-20-1961</b> , and that death occurred at <b>10:35 P.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>W Newcomer</b>				22b. DATE SIGNED <b>11/20/61</b>		22c. PHYSICIAN'S NAME (Type) <b>William Newcomer, M.D., Superintendent</b>	
22d. ADDRESS <b>Mt. Wilson State Hospital, Mt. Wilson, Md.</b>				22e. DATE <b>NOV 24 '61</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>11-23-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>GREEN ACRES Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>Salisbury, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Thornton B. Jolley</b>				25a. REC'D BY REGISTRAR <b>Salisbury, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	

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U.S. AIR FORCE

WASHINGTON, D.C.

OFFICE OF THE

SECRETARY OF

DEFENSE

ATTENTION: MR.

W. H. RYAN

ROOM 3D10

WASHINGTON, D.C.

20340-5000

TELEPHONE: (202) 699-3000

TELETYPE: (202) 699-3000

FACSIMILE: (202) 699-3000



12361

CERTIFICATE OF DEATH

Reg. Dist. No. 12347

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PARKVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X PARKVILLE</u>	
c. LENGTH OF STAY IN 1b <u>3 yrs</u>		d. STREET ADDRESS <u>2419 HARWOOD RD</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2419 HARWOOD RD</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>A</u> Last <u>MORGAN</u>		4. DATE OF DEATH Month <u>Nov</u> Day <u>20</u> Year <u>1961</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 4, 1889</u>
9. AGE (In years lost birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>MICHAEL J. GATELY</u>		14. MOTHER'S MAIDEN NAME <u>ANNA MALONE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>  </u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>FAMILY RECORDS</u>		Address <u>  </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular hemorrhage</u> <u>331X</u> DUE TO <u>Gen'd Arteriosclerosis &amp; hypertension</u> Conditions, if any, which gave rise to immediate cause (c), stating the <u>under-</u> lying cause last. (b) <u>  </u> DUE TO <u>  </u> (c) <u>  </u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs</u> <u>10+ yr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Previous Cerebrovascular damage &amp; hemiplegia</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June</u> , 19 <u>61</u> , to <u>Nov</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>11/20</u> , 19 <u>61</u> , and that death occurred at <u>9<sup>00</sup></u> P. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Frank T. Kasik</u>		ADDRESS (Street, city or town, state) <u>9005 Harford Rd. Balto 14 Md.</u>	
PHYSICIAN'S NAME (Type) <u>FRANK T KASIK</u>		DATE SIGNED <u>11/21/61</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>11-24-61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>NEW CATHEDRAL</u>	22d. LOCATION (City, town, or county) (State) <u>BALTIMORE MARYLAND</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>L. F. EVANS 1 SON</u>		ADDRESS <u>8802 HARFORD RD</u>	
24a. REC'D BY REGISTRAR <u>NOV 24 1961</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Evans</u>	

CERTIFICATE OF DEATH

12101

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*[Faint, illegible text on a death certificate form, likely bleed-through from the reverse side. The form includes fields for name, age, sex, date of death, and cause of death.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

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MAYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Wilson, Maryland</u>		c. LENGTH OF STAY IN 1b <u>32 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Mt. Wilson State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>LOUISE</u> First <u>SHREET</u> Middle <u>MORISON</u> Last		4. DATE OF DEATH Month <u>11</u> Day <u>3</u> Year <u>1961</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9.9.1907</u>
9. AGE (In years last birthday) <u>54</u> yrs.		10. IF UNDER 1 YEAR Months <u>3</u> Days <u>3</u> Hours <u>19</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife (Bookkeeper)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Relay, Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>HARRY SHREET</u>		14. MOTHER'S MAIDEN NAME <u>AMELIA LINK</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>492-26-3464</u>	
17. INFORMANT <u>Hospital Records, Mt. Wilson State Hospital</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Far advanced pulmonary tuberculosis</u> DUE TO (b) <u>29 years</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>INTERVAL BETWEEN ONSET AND DEATH</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10.2.1961</u> to <u>11.3.1961</u> , that (I) (we) last saw the deceased alive on <u>11.3.1961</u> , and that death occurred at <u>6:40 a.m.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Wm. Newcomer</u>		22b. DATE SIGNED <u>11.3.1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>Wm. Newcomer, M.D. Superintendent</u>		22d. ADDRESS <u>Mt. Wilson State Hospital, Mt. Wilson, Md.</u>	
23a. BURIAL, CREMATION, or other disposition (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>11-6-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		23d. LOCATION (City, town, or county) (State) <u>Baltimore</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook, Inc., 1217 St. Paul Street</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 6 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>			

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15365

CERTIFICATE OF DEATH

15365

HARRY SHRETT  
HARRISON (bookkeeper)  
F W  
LOUISE  
THREE MORRIS  
P.P. 1907 24  
J. W. Harrison  
X  
AMELIA LINK  
J. W. Harrison  
X

No. 15365

For a number of years past, the deceased, J. W. Harrison, has been suffering from a long and painful illness, and has been unable to perform his usual duties.

10. 25. 1907  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
12363 CERTIFICATE OF DEATH 12349											
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b> c. LENGTH OF STAY IN 1b <b>1mth 18 dys</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Spring Grove State Hospital</b>						2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville, Maryland</b> d. STREET ADDRESS <b>1408 Merrimac Drive</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Crother</b>			First <b>Horatio</b>			Last <b>Moseley</b>			4. DATE OF DEATH Month <b>November</b> Day <b>8</b> Year <b>19 61</b>		
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5-28-89</b>		9. AGE (In years last birthday) <b>72 yrs.</b>		IF UNDER 1 YEAR Months <b>2</b> Days <b>2</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Steamfitter</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Plumbing</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		
13. FATHER'S NAME <b>Malcolm Moseley</b>						14. MOTHER'S MAIDEN NAME <b>Ann Cardin</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Unknown</b>				16. SOCIAL SECURITY NO. <b>578-07-9565A</b>		17. INFORMANT Address <b>Records: Spring Grove State Hospital</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia; terminal</b> DUE TO (b) <b>491X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Left hemiplegia due to cerebral vascular accident in 1953</b>										INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour <b>e.m.</b> p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Sept. 18, 1961</b> to <b>Nov. 8, 1961</b> , that (I) (we) last saw the deceased alive on <b>Nov. 8, 1961</b> , and that death occurred at <b>11:10 A.M.</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>Stella Wachslar</b>				M.D. <b>Stella Wachslar, M. D.</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>11-8-61</b>			
22c. PHYSICIAN'S NAME (Type) <b>Stella Wachslar, M. D.</b>				22d. ADDRESS <b>Spring Grove State Hospital Catonsville, Maryland</b>							
23a. <del>DATE</del> CREMATION, (Specify) <b>11-10-1961</b>		23b. DATE THEREOF <b>11-10-1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>CEDAR HILL CREMATORY</b>		23d. LOCATION (City, town or county) <b>SUITLAND, MD.</b> (State)					
24. FUNERAL DIRECTOR'S SIGNATURE <b>Mac N. Morris</b> ADDRESS <b>3901 N. FAIRFAX DR. BELVA</b>						25a. REC'D BY REGISTRAR <b>NOV 13 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12364

## CERTIFICATE OF DEATH

12350

<b>1. PLACE OF DEATH</b> a. COUNTY <i>Baltimore</i> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonsville</i> c. LENGTH OF STAY IN 1b <i>9 days</i> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Spring Grove State Hosp</i>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Prince George's</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>4227-34th Street Mt Rainier, Md</i> d. STREET ADDRESS <i>4227-34th St. - 1647-2</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <i>Samuel</i> Middle <i>Martin</i> Last <i>Moudy</i>		<b>4. DATE OF DEATH</b> Month <i>11</i> Day <i>19</i> Year <i>1961</i>					
<b>5. SEX</b> <i>M</i>	<b>6. COLOR OR RACE</b> <i>W</i>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <i>3-30-1887</i>	<b>9. AGE</b> (In years last birthday) <i>74 yrs.</i>	<b>IF UNDER 1 YEAR</b> Months <i>7</i> Days <i>4</i>	<b>IF UNDER 24 HRS.</b> Hours <i>19</i> Min. <i>61</i>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <i>Wheelwright</i>		<b>10b. KIND OF BUSINESS, OR INDUSTRY</b> <i>Retired</i>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <i>Washington D.C.</i>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <i>U. S. A.</i>	
<b>13. FATHER'S NAME</b> <i>John L Moudy</i>			<b>14. MOTHER'S MAIDEN NAME</b> <i>Anna Souders</i>				
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <i>Unknown</i>		<b>16. SOCIAL SECURITY NO.</b> <i>Unknown</i>		<b>17. INFORMANT</b> <i>Records: Spring Grove State Hospital</i>		<b>Address</b>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebrovascular accident (thrombosis?)</i> DUE TO (b) <i>Cerebrovascular arteriosclerosis</i> DUE TO (c) <i>Generalized arteriosclerosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						<b>INTERVAL BETWEEN ONSET AND DEATH</b> <i>7 h.</i>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b> <i>Extreme malnutrition and Anemia</i>						<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Hour <i>19</i> a.m. <i>19</i> p.m.	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town)</b>	<b>(County)</b>	<b>(State)</b>		
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <i>Nov 10 1961</i> , to <i>Nov 19 1961</i> , that (I) (we) last saw the deceased alive on <i>Nov 19 1961</i> , and that death occurred at <i>11 A.M.</i> from the causes and on the date stated above.							
<b>22a. SIGNATURE</b> <i>Loretta Hsu, M.D.</i>		<b>22b. DATE SIGNED</b> <i>NOV. 19, 61</i>					
<b>22c. PHYSICIAN'S NAME</b> (Type) <i>LORETTA HSU</i>		<b>22d. ADDRESS</b> <i>SPRING GROVE STATE HOSPITAL</i>					
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <i>Burial</i>	<b>23b. DATE THEREOF</b> <i>11/22/61</i>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <i>Ft. Lincoln</i>		<b>23d. LOCATION</b> (City, town or county) <i>Colmar Manor,</i>		<b>(State)</b> <i>Md.</i>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <i>Francis Gasch's Sons</i>		<b>ADDRESS</b> <i>Hyattsville, Maryland</i>		<b>25a. REC'D BY REGISTRAR</b> <i>NOV 21 '61</i>	<b>25b. REGISTRAR'S SIGNATURE</b> <i>Arthur L. Kraus</i>		

M

4351

Oct 1991

## MEDICAL CERTIFICATION

VS. A15ME  
5M 7/59

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TOWSON</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TOWSON</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>1580 DOXBURY RD.</b>		d. STREET ADDRESS <b>1580 DOXBURY RD.</b>	
3. NAME OF DECEASED (Type or print) <b>JAMES</b>		4. DATE OF DEATH Month <b>NOV</b> Day <b>22</b> Year <b>1961</b>	
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>MAY 7 1931</b>	
9. AGE (In years last birthday) <b>30</b> yrs.		10. IF UNDER 1 YEAR Months <b>30</b> Days <b>0</b>	
11. IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>PIERCE MURRAY</b>		14. MOTHER'S MAIDEN NAME <b>MURPHY</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>1-27-61</b>	
17. INFORMANT <b>MRS Colette MURRAY - same</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY ARTERY DISEASE</b> DUE TO (b) <b>420.1</b> DUE TO (c) <b>1 yr.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>NO</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>William A. Pillsbury</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>WILLIAM A. PILLSBURY</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. BURIAL, CREMATION, REMOVAL (Specify) <b>11-27-61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>CALVARY CEM.</b>	
22b. DATE THEREOF		22d. LOCATION (City, town, or country) (State) <b>L.I. YONKERS N.Y.</b>	
23. FUNERAL DIRECTOR <b>L. J. Ruck</b>		24a. REC'D BY REGISTRAR <b>Nov 24 '61</b>	
ADDRESS <b>5305 HARFORD Rd.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12366

## CERTIFICATE OF DEATH

12352

<b>1. PLACE OF DEATH</b> a. COUNTY <u>BALTIMORE</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u> c. LENGTH OF STAY in 1b <u>15 YRS</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>5901 EDMONDSON AVE.</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X CATONSVILLE</u> d. STREET ADDRESS <u>5901 EDMONDSON AVE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
<b>3. NAME OF DECEASED</b> (Type or print) <u>ALBERT GEORGE MURRELL</u> First Middle Last				<b>4. DATE OF DEATH</b> <u>NOV. 27, 1961</u> Month Day Year									
<b>5. SEX</b> <u>M</u>		<b>6. COLOR OR RACE</b> <u>W</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>AUG. 2, 1889</u>		<b>9. AGE</b> (In years last birthday) <u>72</u> yrs.		<b>IF UNDER 1 YEAR</b> Months Days Hours Min.		<b>IF UNDER 24 HRS.</b> Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>RETIRED CANDY SALESMAN, LEWIS CANDY</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>MD.</u>				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>U.S.A.</u>					
<b>13. FATHER'S NAME</b> <u>GEORGE MURRELL</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>UNKNOWN</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown)				<b>16. SOCIAL SECURITY NO.</b>				<b>17. INFORMANT</b> Address <u>MRS LOLA LEWIS, 5901 EDMONDSON AVE.</u>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL VASCULAR ACCIDENT</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>HYPERTENSIVE HEMISPHERIC CEREBRAL</u> DUE TO <u>VASCULAR DISEASE</u> (c) <u>PULMONARY EMBOLISM</u>													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)													
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)									
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>	
<b>21. I certify</b> that (I) (this hospital) attended the deceased from <u>11/1</u> 19 <u>61</u> to <u>11/27</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>11/27</u> 19 <u>61</u> , and that death occurred <u>11/27</u> 19 <u>61</u> , from the causes and on the date stated above.													
<b>22a. SIGNATURE</b> <u>John W. Shaw</u> M.D.				<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>				<b>22b. DATE SIGNED</b> <u>11/28/61</u>					
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>JOHN W. SHAW M.D.</u>				<b>22d. ADDRESS</b> <u>5901 EDMONDSON AVE. BALTO. MD.</u>									
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>BURIAL</u>				<b>23b. DATE THEREOF</b> <u>11/30/61</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>LOUDON PK. CEMT.</u>				<b>23d. LOCATION</b> (City, town or county) <u>BALTO. MD.</u> (State)			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>WALTER FIDIR, 4101 EDMONDSON AVE.</u>				<b>ADDRESS</b>				<b>25a. REC'D BY REGISTRAR</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles E. Hume</u>			
<b>DATE</b> <u>NOV 30 '61</u>													

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12367

Item 12 Film G-301

11/29/61 iwk

12353

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Parkville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Parkville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>8807 Baker St.</b>		d. STREET ADDRESS <b>8807 Baker St</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Josephine Niewiadomski</b>		4. DATE OF DEATH <b>Nov. 18/61</b> 19 <b>61</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 8, 71</b>
9. AGE (In years last birthday) <b>90</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Poland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James Golatowski</b>		14. MOTHER'S MAIDEN NAME <b>Unk.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Clemantine Gronski</b>		Address <b>8807 Baker St</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized Lymphomata</b> <b>202.1</b> DUE TO <b>with marked debilitation</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Gen'd Arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Area of Severe Stom infections base spine</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <b>11/20/61</b> Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1/20/59</b> to <b>Nov. 18/61</b> , that (I) (we) last saw the deceased alive on <b>11/18/61</b> , and that death occurred on <b>11/20/61</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Frank T. Kasik</b>		22b. DATE SIGNED <b>11/20/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>FRANK T KASIK</b>		22d. ADDRESS <b>9005 HARFORD Rd</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Buried 11/30</b>		23b. DATE THEREOF <b>11/30</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Holy Rosary</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Fred W. Ozaewski</b>		25a. REC'D BY REGISTRAR <b>NOV 21 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Huns</b>			

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*[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "Baltimore" and "Elma" are faintly visible.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Pages 1 and 2 should be filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
12369 CERTIFICATE OF DEATH 12355									
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>					c. LENGTH OF STAY IN lb <b>4 Days</b>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Veterans Administration Hospital</b>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore 22</b>				
3. NAME OF DECEASED (Type or print) <b>PAUL</b>					d. STREET ADDRESS <b>8103 Beechwood Road</b>				
5. SEX <b>Male</b>					4. DATE OF DEATH <b>November 17 19 61</b>				
6. COLOR OR RACE <b>White</b>					7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Soldier - Retired</b>					8. DATE OF BIRTH <b>June 26, 1911</b>				
10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Army</b>					9. AGE (In years last birthday) yrs. <b>50</b>				
11. BIRTHPLACE (County & State, or foreign country) <b>Edenborn, Pennsylvania</b>					12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>				
13. FATHER'S NAME <b>John Plisko</b>					14. MOTHER'S MAIDEN NAME <b>Anne Redus</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>Yes WW II</b>					17. INFORMANT <b>Clinical Recored, VAH, Baltimore 18, Maryland</b> <b>FORT HOWARD DIVISION</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Posterolateral Myocardial Infarction</b> DUE TO (b) <b>Coronary Sclerosis</b> (c) <b>Fatty Liver and Hepatic Cirrhosis</b>					INTERVAL BETWEEN ONSET AND DEATH <b>12 Hours</b> <b>Unknown</b> <b>Unknown</b>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>				
1. <b>Bilateral Bronchopneumonia, recent.</b>					2. <b>Cerebral Edema.</b>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>November 13, 1961</b> to <b>November 17, 1961</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>November 17, 1961</b> , and that death occurred at <b>9:10 A.M.</b> from the causes and on the date stated above.									
22a. SIGNATURE <b>Sebastian Russo M.D.</b>					22b. DATE SIGNED <b>11/17/61</b>				
22c. PHYSICIAN'S NAME (Type) <b>SEBASTIAN RUSSO, M.D.</b>					22d. ADDRESS <b>VAH, BALTIMORE 18, MD. FORT HOWARD DIVISION</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>					23b. DATE THEREOF <b>11-21-61</b>				
23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cemetery</b>					23d. LOCATION (City, town or county) (State) <b>Baltimore 28, Maryland</b>				
24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook-Blight, Inc., 6009 Harford Rd., Balto. 14, Md.</b>					25a. REC'D BY REGISTRAR <b>NOV 20 '61</b>				
					25b. REGISTRAR'S SIGNATURE <b>Arthur S. House</b>				

Mr. Cook-Bird, Inc., 5000 Highway 24, Dallas, Texas.

• C. H. DUBOIS, HALLS, N. D.

Postgraduate Institute of Technology

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

**CERTIFICATE OF DEATH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12370

12356

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Baltimore</b> MARYLAND		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>1415 Shefford Road, Zone 12</b>		d. STREET ADDRESS <b>1415 Shefford Road</b>	
<b>3. NAME OF DECEASED</b> (Type or print) <b>ANNIE REGINA PORCELLA</b>		<b>4. DATE OF DEATH</b> <b>Nov. 29 19 61</b>	
<b>5. SEX</b> <b>female</b>	<b>6. COLOR OR RACE</b> <b>white</b>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>10/18/1874</b>
<b>9. AGE</b> (In years last birthday) <b>87</b>		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>housewife</b>	
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Baltimore, Md.</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<b>13. FATHER'S NAME</b> <b>William T. DeVaughn</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>unknown</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b>	
<b>17. INFORMANT</b> <b>Stella Steiner, dght, above</b>		<b>Address</b>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular accident</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>generalized arteriosclerosis</b> (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>2 hours</b> <b>years</b>			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>April 19 61</b> , to <b>November 19 61</b> , that (I) (we) last saw the deceased alive on <b>November 28 19 61</b> , and that death occurred at <b>4:30 P.M.</b> from the causes and on the date stated above.			
<b>22a. SIGNATURE</b> <b>J.F. Palmisano</b>		<b>22b. DATE SIGNED</b> <b>12-1-61</b>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>J.F. Palmisano, M.D.</b>		<b>22d. ADDRESS</b> <b>6608 Loch Raven Blvd. Balto Md.</b>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>12/2/61</b>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Mt. Olivet Cemetery</b>		<b>23d. LOCATION</b> (City, town or county) (State) <b>Baltimore, Md.</b>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Charles E. Schimunek Funeral Home</b>		<b>25a. REC'D BY REGISTRAR</b> <b>DEC 5 '61</b>	
<b>25b. REGISTRAR'S SIGNATURE</b> <b>Anthony S. Kraus</b>		<b>25c. ADDRESS</b>	



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Baltimore

MD.

Baltimore

1-15 Bedford Road, Case 12

1-15 Bedford Road

Nov. 23

Nov. 23

white

10/12/1974

87

hobbsville

at home

Baltimore, MD.

William J. Foxglen

unknown

Stella Steiner, 600, above

Burial 12/2/01

St. Oliver Cemetery

Baltimore, MD.

Charles L. Schinnerer Funeral Home

3331 Richman Lane

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any fee is necessary, it should be paid to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

# MARYLAND STATE DEPARTMENT OF HEALTH

12357 STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE 12</b> c. LENGTH OF STAY IN 1b <b>10 MOS.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>84 MURDOCK RD.</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>BALTO.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE 12</b> d. STREET ADDRESS <b>184 MURDOCK RD.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>EDGAR M. WILLIAM POWLEY</b>				4. DATE OF DEATH <b>NOV. 25 1961</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-24-92</b>	9. AGE (In years last birthday) <b>69</b> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FIREMAN-RET.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>MUNICIPAL</b>		11. BIRTHPLACE (State or foreign country) <b>PA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JOHN POWLEY</b>			14. MOTHER'S MAIDEN NAME <b>GLASS</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. <b>WW I 104-30-6713</b>		17. INFORMANT <b>ROBERT J. POWLEY</b> Address <b>5522 COUNCIL BALTO. 27</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMATOSIS</b> <b>199X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <b>4 YRS</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>William A. Pillsbury</b>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>11-25-61</b>			
EXAMINER'S NAME (Type) <b>William A. Pillsbury</b>		DEPUTY MEDICAL EXAMINER <b>Timonium Md.</b>		Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or country) (State)				
<b>Removal/Burial Nov. 28, 1961</b>		<b>Ashland Cemetery</b>	<b>Carlisle, Pennsylvania</b>				
23. FUNERAL DIRECTOR <b>John Burm's Sons, Towson, Maryland</b>		24a. REC'D BY REGISTRAR <b>DEC 1 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

MEDICAL CERTIFICATION

2



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HOSPITAL E. LAMBERG - CENTRAL ST. ST. LOUIS  
HARRY AND ESTATE HUSBAND OF NEAL

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VR A15 (4)  
15M 9/60

## 12372

12358

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>	<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>	c. LENGTH OF STAY IN lb <b>10 days</b>
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>George</b>	4. DATE OF DEATH <b>Nov. 28, 1961</b>
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 25, 1875</b>
9. AGE (In years last birthday) <b>86 yrs.</b>	10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>
11. IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>	12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
13. FATHER'S NAME <b>George Albert Price</b>	14. MOTHER'S MAIDEN NAME <b>Sarah Ann Huges</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>unknown</b>	16. SOCIAL SECURITY NO. <b>unknown</b>
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>	Address <b>SPRING GROVE STATE HOSPITAL</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive heart failure</b> 420.8 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) <b>Arteriosclerotic heart disease</b> DUE TO (c)	INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Transition associated with Senile Brain Disease</b>	19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. <input type="checkbox"/> p.m. <input type="checkbox"/> <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (H) (this hospital) attended the deceased from <b>Nov. 17, 1961</b> to <b>Nov. 28, 1961</b> , that (I) (we) last saw the deceased alive on <b>Nov. 28, 1961</b> , and that death occurred at <b>3:30 P.M.</b> from the causes and on the date stated above	22b. DATE SIGNED <b>11/29/61</b>
22a. SIGNATURE <b>Stella Wachslar</b>	ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) <b>STELLA WACHSLER</b>	22d. ADDRESS <b>SPRING GROVE STATE HOSPITAL</b> <b>Catonsville 28, Maryland</b>
23a. BURIAL CREMATION, REMOVAL (Specify) <b>12/1/61</b>	23b. DATE THEREOF <b>12/1/61</b>
23c. NAME OF CEMETERY OR CREMATORY <b>Proctor</b>	23d. LOCATION (City, town or county) (State) <b>Proctor Md.</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur L. Hines</b>	25a. REC'D BY REGISTRAR <b>DEC 5 '61</b>
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>	



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OFFICE OF THE

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

12373

12359

<b>1. PLACE OF DEATH</b> a. COUNTY <u>BALTO.</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u> c. LENGTH OF STAY IN 1b  d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>SHADY NOOK CONV. HOME</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> <span style="float: right;">b. COUNTY <u>HOWARD</u> ✓</span> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>ELLICOTT CITY</u> <span style="float: right;">13X-2</span> d. STREET ADDRESS <u>316 MACALPINE RD.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
<b>3. NAME OF DECEASED</b> (Type or print) <u>HARRY PRUST</u> First Middle Last			<b>4. DATE OF DEATH</b> <u>NOV. 12</u> 19 <u>61</u> Month Day Year											
<b>5. SEX</b> <u>M</u>		<b>6. COLOR OR RACE</b> <u>W</u>		<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>										
<b>8. DATE OF BIRTH</b> <u>10/3/70</u>		<b>9. AGE</b> (In years last birthday) <u>91</u> yrs. IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____												
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>FUNERAL DIRECTOR</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>  		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>ILL.</u>										
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>														
<b>13. FATHER'S NAME</b> <u>DANIEL PRUST</u>			<b>14. MOTHER'S MAIDEN NAME</b> <u>LYDIA BALTHIS</u>											
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give year or dates of service) <u>no</u>		<b>16. SOCIAL SECURITY NO.</b>  		<b>17. INFORMANT</b> <u>Quane Prust</u> Address _____										
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <table style="width: 100%;"> <tr> <td style="width: 30%;"> <b>PART I. DEATH WAS CAUSED BY:</b>  <b>IMMEDIATE CAUSE (a)</b>  <u>420.1</u> </td> <td style="width: 40%;"> <b>DUE TO</b>  <u>CORONARY THROMBOSIS</u> </td> <td style="width: 30%;"> <b>INTERVAL BETWEEN ONSET AND DEATH</b>  <u>5 days</u> </td> </tr> <tr> <td> <b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b> </td> <td> <b>(b)</b>  <u>Arterio sclerosis</u> </td> <td> <u>Unknown</u> </td> </tr> <tr> <td></td> <td> <b>DUE TO (c)</b>    </td> <td></td> </tr> </table>						<b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <u>420.1</u>	<b>DUE TO</b> <u>CORONARY THROMBOSIS</u>	<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>5 days</u>	<b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b>	<b>(b)</b> <u>Arterio sclerosis</u>	<u>Unknown</u>		<b>DUE TO (c)</b>  	
<b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <u>420.1</u>	<b>DUE TO</b> <u>CORONARY THROMBOSIS</u>	<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>5 days</u>												
<b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b>	<b>(b)</b> <u>Arterio sclerosis</u>	<u>Unknown</u>												
	<b>DUE TO (c)</b>  													
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b> <u>Pneumonia left Base</u>														
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)												
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)  										
<b>20f. (City or town)</b> _____ (County) _____ (State) _____														
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>from 10/16/61</u> <b>to</b> <u>11/12/61</u> <b>that (I) (we) last saw the deceased alive on</b> <u>11/10/61</u> <b>and that death occurred at</b> <u>9:25</u> <b>M.</b> <b>from the causes and on the date stated above.</b>														
<b>22a. SIGNATURE</b> <u>Cliff Ratliff</u> M.D.			<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <u>11/13/61</u>									
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>CLIFF RATLIFF, JR.</u>			<b>22d. ADDRESS</b> <u>4605 EDMONDSON AVE.</u>											
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>BURIAL</u>		<b>23b. DATE THEREOF</b> <u>11/17/61</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>WALNUT PRAIRE</u>										
<b>23d. LOCATION</b> (City, town or county) <u>WEST UNION, ILL.</u>		(State) _____												
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Barbara Pratt &amp; Son, Catonsville Md</u>			<b>25a. REC'D BY REGISTRAR</b> <u>NOV 14 '61</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles L. Knease</u>									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
 15M 9/60

1883

1883



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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12374

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12360

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Caton Ridge Nursing Home</b>			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto.</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b> d. STREET ADDRESS <b>742 Edmondson Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>C.</b> Last <b>Ralston</b>			4. DATE OF DEATH Month <b>Nov.</b> Day <b>3/61</b> Year <b>19</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 1870</b>	9. AGE (In years last birthday) <b>91</b> yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>H.W.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Balto. Md.</b>	
13. FATHER'S NAME <b>Alexander Simpson</b>			14. MOTHER'S MAIDEN NAME <b>Agnes ----</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>(Yes, no, or unknown)</b>			16. SOCIAL SECURITY NO. <b>(If yes give number or date of service)</b>		
17. INFORMANT <b>Mrs. Hattie Frederick, 1002 Frances Ave</b>			Address <b>Relay 27, Md</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>443X Congestive Heart Failure</b> DUE TO (b) <b>Hypertensive Heart Disease</b> DUE TO (c) <b>Cerebral Thrombosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Nov 3 1961</b>					INTERVAL BETWEEN ONSET AND DEATH <b>1 yr.</b> <b>3+ yrs.</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Oct 4 1958</b> to <b>Nov 3 1961</b> , that (I) (we) last saw the deceased alive on <b>Nov 3 1961</b> , and that death occurred at <b>11:55 P.M.</b> from the causes and on the date stated above.					
22a. SIGNATURE <b>John N. Snyder</b> 22c. PHYSICIAN'S NAME (Type) <b>JOHN N. SNYDER M.D.</b>			22b. DATE SIGNED <b>Nov 5, 1961</b>		
22d. ADDRESS <b>6348 FREDERICK RD BALTIMORE 28 MD.</b>			22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/6/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park</b>	
23d. LOCATION (City, town or county) <b>Balto. 29, Md</b>		23e. REC'D BY REGISTRAR <b>NOV 8 '61</b>		23f. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Witzke F.D. 4101 Edmondson Ave. Balto. 29, Md</b>					

MEDICAL CERTIFICATION

(M)

1234

1234

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JOHN K. ...  
M.D. ...

1/10/11  
1111 ...

## 12361

## MEDICAL CERTIFICATION

VR A15 (4)  
15M 9/60

18881

18881





1  
M  
I  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Pages 3 and 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12376  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
12362

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>—</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN 1b <b>23yr4mth16dys</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
3. NAME OF DECEASED (Type or print) <b>Christian Redmers</b>				d. STREET ADDRESS <b>600 South North Point Road</b>			
5. SEX <b>male</b>				6. COLOR OR RACE <b>white</b>			
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>Redmers</b>				8. DATE OF DEATH <b>November 6 19 61</b>			
9. AGE (In years last birthday) <b>81</b> yrs.				10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>			
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
13. FATHER'S NAME <b>Charles Redmers</b>				14. MOTHER'S MAIDEN NAME <b>Lorraine ?</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>unknown</b>				16. SOCIAL SECURITY NO. <b>unknown</b>			
17. INFORMANT <b>Records; SPRING GROVE STATE HOSPITAL</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary edema</b> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Cardiac failure</b> (c) <b>Arteriosclerotic heart disease</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Ulcer of leg; right</b>				INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that <del>10</del> (this hospital) attended the deceased from <b>June 3, 1938</b> , to <b>Nov. 6, 1961</b> , that (I) (we) last saw the deceased alive on <b>Nov. 6, 1961</b> , and that death occurred at <b>3:00 p.m.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Stella Wachslar</b> M.D.				22b. DATE SIGNED <b>11-6-61</b>			
22c. PHYSICIAN'S NAME (Type) <b>Stella Wachslar, M. D.</b>				22d. ADDRESS <b>SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>11/8/61</b>			
23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Carmel Cemetery</b>				23d. LOCATION (City, town or county) (State) <b>Baltimore, Md.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>ULLRICH FUNERAL HOME - DUNPAK MD</b>				25. REC'D BY REGISTRAR <b>DATE NOV 8 '61</b>			
25b. REGISTRAR'S SIGNATURE <b>Arthur J. Frank</b>							

15018

15018

(M)

(1)



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12377

## CERTIFICATE OF DEATH

Reg. Dist. No. 12363

1. PLACE OF DEATH o. COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arbutus</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Arbutus</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4102 West Drive</u>		d. STREET ADDRESS <u>4102 West Drive</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>William Thomas Reigle</u>		4. DATE OF DEATH Month Day Year <u>Nov. 9 1961</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 3, 1879</u>
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Telephone Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Reigle</u>		14. MOTHER'S MAIDEN NAME <u>Frances ?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>212-05-0905</u>	
17. INFORMANT Address <u>Mrs. Virginia Dean - 4102 West Dr.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Coronary thrombosis</u> DUE TO (b) <u>Arteriosclerotic CVD</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>— yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov. 3</u> , 19 <u>61</u> , to <u>Nov. 9</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>Nov. 3</u> , 19 <u>61</u> , and that death occurred at <u>6 P.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Herbert J. Levickas</u> M.D.		ADDRESS (Street, city or town, state) <u>5305 East Drive</u> DATE SIGNED <u>11/10/61</u>	
PHYSICIAN'S NAME (Type) <u>Herbert J. Levickas</u>		<u>Baltimore - 27, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 13, 1961</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Louren Park</u>		22d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John T. Stansbury</u> ADDRESS <u>6411 Windsor Mill Rd</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 13 '61</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1941

(M)

Form with multiple sections for recording death information, including fields for name, date, time, place, cause, and signature. The form is oriented horizontally but contains vertical text labels for various fields.

NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

TIME: \_\_\_\_\_

PLACE: \_\_\_\_\_

CAUSE: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_

Vertical text on the right margin, likely a filing or processing stamp.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12378

CERTIFICATE OF DEATH

Reg. Dist. No.

12364

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RODGERS FORGE</u>		c. LENGTH OF STAY IN 1b <u>28 MO.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>ARMACANT NURSING HOME REGISTER AVE.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MARGARET</u> Middle <u>A.</u> Last <u>REILLY</u>		4. DATE OF DEATH Month <u>Nov</u> Day <u>14</u> Year <u>1961</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 27, 1896</u>
9. AGE (In years last birthday) <u>85</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>John DeLaney</u>		14. MOTHER'S MAIDEN NAME <u>MARY FAIR</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NAME</u>	
17. INFORMANT <u>FAMILY RECORDS</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>153.9</u> DUE TO <u>Pneumonia (Bronchial)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Metastatic CA from Large Bowel</u> DUE TO <u>Descending</u> (c) <u>Generalized Hypertensive C-V Disease</u> DUE TO <u>16 yrs</u>		INTERVAL BETWEEN ONSET AND DEATH <u>72 Day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct 10, 1947</u> to <u>Nov 14, 1961</u> , that I last saw the deceased alive on <u>Nov 14, 1961</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Charles F O'Donnell</u> M.D.		ADDRESS (Street, city or town, state) <u>7501 YORK RD</u> DATE SIGNED <u>11/15/61</u>	
PHYSICIAN'S NAME (Type) <u>Charles F O'Donnell</u>		<u>Balto #4 Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>11-18-61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>NEW CATHEDRAL LEM.</u>	22d. LOCATION (City, town, or county) (State) <u>BALTIMORE MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. F. EVANS &amp; SON 8802 HARTFORD RD</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 21 '61</u>	
24b. REGISTRAR'S SIGNATURE <u>Anthony P. Hanna</u>			

12378

CERTIFICATE OF DEATH

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DEATH

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1  
FOR STATE  
HEALTH DEPT.

TO DEPT. MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MEDICAL CERTIFICATION

<div> <div> <div>1</div> <div>FOR STATE HEALTH DEPT.</div> </div> <div> <div>12379</div> <div>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> </div> <div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>12365</div> </div> </div>											
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b> c. LENGTH OF STAY IN 1b <b>12 Years</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Res., 49 Mavista Avenue</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b> d. STREET ADDRESS <b>49 Mavista Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>MARY C. REISSER</b>				4. DATE OF DEATH Month <b>November</b> Day <b>15</b> Year <b>61</b>				5. SEX <b>Female</b>			
6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 21, 1917</b>		9. AGE (In years last birthday) <b>44</b> yrs.		IF UNDER 1 YEAR Months <b>11</b> Days <b>14</b> Hours <b>15</b> Min.		IF UNDER 24 HRS. Hours <b>15</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Walter Sawyer</b>				14. MOTHER'S MAIDEN NAME <b>Ann Forbs</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>No</b>				17. INFORMANT <b>Robert Reisser</b> Address <b>49 Mavista Ave. 22, Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cor Pulmonale</b> <b>002X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Active and Inactive Pulmonary Tuberculosis.</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)										INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour <b>a.m.</b> p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>Charles S. Petty</b>				M.D. <b>Charles S. Petty, M.D.</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
				Address (Street, city, town, or county)				DATE SIGNED <b>11/15/61</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <b>Nov. 17, 1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Mem. Park</b>		22d. LOCATION (City, town, or country) (State) <b>Washington Blvd. Md..</b>					
23. FUNERAL DIRECTOR <b>JOHN J. DUDA</b> ADDRESS <b>7922 Wise Ave. 22, Md..</b>				24a. REC'D BY REGISTRAR <b>NOV 21 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Charles S. Petty</b>					

QUEST

1  
FOR STATE  
HEALTH DEPT.

TO DEATH MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME  
SM 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
12380 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 12366

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore 2, Bx 449, Rt. 15</b> c. LENGTH OF STAY IN 1b <b>Baltimore 2</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore 2</b> d. STREET ADDRESS <b>Box 449 - Rt. #15</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>ROBERT</b>				4. DATE OF DEATH Month <b>11</b> Day <b>24</b> Year <b>1961</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>June 1893</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Handyman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>General Repair</b>		11. BIRTHPLACE (State or foreign country) <b>W. Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Lou Rhodenheaver</b>				14. MOTHER'S MAIDEN NAME <b>Cecelia Johnson</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>?</b>		16. SOCIAL SECURITY NO. <b>?</b>		17. INFORMANT <b>Sontol Bongiorno 2711 Greenmount Ave.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> <b>4221</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) DUE TO cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 1b.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Russell S. Fisher</b> EXAMINER'S NAME (Type) <b>RUSSELL S. FISHER, M.D.</b>				CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>11-27-61</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/29/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		22d. LOCATION (City, town, or country) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR <b>James E. Brudzinski</b> ADDRESS <b>1407 Eastern Ave.</b>				24a. REC'D BY REGISTRAR <b>NOV 30 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Wm. L. Thuma</b>	

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

12381

12367

1. PLACE OF DEATH a. COUNTY <u>Baltimore Co.</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>a.a.</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Edtonville</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> <u>128-2</u>			
c. LENGTH OF STAY IN 1b				d. STREET ADDRESS <u>PT. 3 R.F.D.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Forest Haven</u>				a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Frank B. Rinn</u>				4. DATE OF DEATH Month Day Year <u>Nov. 29</u> <u>1961</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>7/27/81</u>	9. AGE (In years last birthday) <u>80</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>ret.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Francis Rinn</u>				14. MOTHER'S MAIDEN NAME <u>Mary McCreary</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>Col. Frank B. Rinn</u>		17. INFORMANT <u>Col. Frank B. Rinn</u>			Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIO SCLEROTIC CHRONIC VASCULAR DISEASE</u> DUE TO <u>HEMIPLEGIA</u> (b) <u>HEMIPLEGIA</u> DUE TO <u>MALINARIAL EDEMA</u> (c) <u>MALINARIAL EDEMA</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</u>							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that (I) (this hospital) attended the deceased from <u>11/1</u> , 19 <u>61</u> , to <u>11/29</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>11/29</u> , 19 <u>61</u> , and that death occurred at <u>9 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>John H. Shaw M.D.</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>11/29/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>John H. Shaw M.D.</u>				22d. ADDRESS <u>5500 EDMONDSON AVE. BALTIMORE, MD.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>cremation</u>	23b. DATE THEREOF <u>11/30/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Ht. Lincolnton</u>	23d. LOCATION (City, town or county)	(State)			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Macdratt &amp; Son - Patonsville 28</u>				25a. REC'D BY REGISTRAR <u>DEC 1 '61</u>	25b. REGISTRAR'S SIGNATURE <u>Charles E. Kline</u>		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/60

1951

1951





## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12382

## CERTIFICATE OF DEATH

Reg. Dist. No. 12368

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. LENGTH OF STAY IN 1b <u>6 months</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore X</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Towson Nursing Home</u>				d. STREET ADDRESS <u>6304 Beechwood Rd 12</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ALyce R Robinson</u>				4. DATE OF DEATH Month Day Year <u>Nov 11 1961</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug-24 1881</u>		9. AGE (In years last birthday) yrs. <u>80</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>South Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John James Dial</u>				14. MOTHER'S MAIDEN NAME <u>Lane Elizabeth Jacobs</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Edward E. Robinson 6304 Beechwood Rd 12</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1</u> DUE TO <u>Incompensative Cardio Vascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 20 1959</u> to <u>Nov. 11 1961</u> , that I last saw the deceased alive on <u>Nov 11 1961</u> and that death occurred at <u>8:15 P. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Laurence C. Post</u> M.D.				ADDRESS (Street, city or town, state) <u>6805 York Rd Baltimore 12 md</u>		DATE SIGNED <u>11/13/61</u>	
PHYSICIAN'S NAME (Type) <u>LAURENCE C. Post</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov 14-1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Moreland Memorial</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Co md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Glenn F. Seitz</u>				ADDRESS <u>5209 York Rd 12 md</u>		24a. REC'D BY REGISTRAR <u>NOV 16 '61</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
12383						12369					
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 18</b> c. LENGTH OF STAY IN lb <b>25 Days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Veterans Administration Hospital</b>					
3. NAME OF DECEASED (Type or print) <b>LINWOOD G. ROBINSON</b>						4. DATE OF DEATH Month Day Year <b>November 30 19 61</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 26, 1917</b>		9. AGE (In years last birthday) <b>44 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Porter</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Chemical Company</b>				11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Samuel RobinsOnn</b>						14. MOTHER'S MAIDEN NAME <b>Jennie Knorr</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WW II</b>						16. SOCIAL SECURITY NO. <b>218-05-0789</b>					
17. INFORMANT <b>Clinical Records, VAH, Baltimore 18, Maryland</b> <b>Fort Howard Division</b>						17. ADDRESS <b>Baltimore 18, Maryland</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>LEFT VENTRICULAR HYPERTROPHY</b> DUE TO <b>CHRONIC NEPHROSCLEROSIS</b> (b) <b>BRONCHOPNEUMONIA</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>XXXXX</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN TERMINAL</b>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <b>November 5, 1961</b> , to <b>November 30, 1961</b> , that (X) (we) last saw the deceased alive on <b>November 30, 1961</b> , and that death occurred at <b>11:25 A.M.</b> from the causes and on the date stated above.											
22a. SIGNATURE <i>Sebastian Russo</i>						22b. DATE SIGNED <b>12/1/61</b>					
22c. PHYSICIAN'S NAME (Type) <b>SEBASTIAN RUSSO, M.D.</b>						22d. ADDRESS <b>VAH, BALTO. 18, MARYLAND, FT. HOWARD DIVISION</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-4-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cemetery Baltimore 28, Maryland</b>				23d. LOCATION (City, town or county) (State)			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Elroy O. Wilson 1000 Brantley Ave., Balto. 17, Md.</b>						25a. REC'D BY REGISTRAR <b>DEC 6 '61</b>		25b. REGISTRAR'S SIGNATURE <i>William S. Wilson</i>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LANSDOWNE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X LANSDOWNE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>132 HAZEL AVE.</u>				d. STREET ADDRESS <u>132 HAZEL AVE.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>EMMA CHARLOTTE ROMM</u>				4. DATE OF DEATH Month Day Year <u>NOVEMBER 4, 1961</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>OCT. 24, 1892</u>	
9. AGE (In years last birthday) <u>69</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>DOMESTIC</u>			
13. FATHER'S NAME <u>RICHARD OTTO</u>				14. MOTHER'S MAIDEN NAME <u>OLGA HORN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>NONE</u>			
17. INFORMANT <u>Miss D. Romm</u>				Address <u>132 HAZEL AVE</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>157X</u> DUE TO <u>ca of the pancreas</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c) INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>11-4-61</u> to <u>11-4-61</u> , that (I) (we) last saw the deceased alive on <u>11-4-61</u> and that death occurred at <u>5:38</u> A. M. from the causes and on the date stated above.							
22a. SIGNATURE <u>Stanley Ankudav</u>				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>STANLEY ANKUDAS</u>				22d. ADDRESS <u>1802 W. Paet</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>11-8-61</u>			
23c. NAME OF CEMETERY OR CREMATORY <u>WESTERN</u>				23d. LOCATION (City, town, or county) (State) <u>BALTIMORE, Md.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Charles W. Miller</u>				25a. REC'D BY REGISTRAR <u>NOV 7 '61</u>			
ADDRESS <u>2101 Audubon Ave.</u>				25b. REGISTRAR'S SIGNATURE <u>Charles S. Hume</u>			

15310

RETURN OF INCOME

1981

(M)

1. Name of taxpayer: [illegible]  
2. Social Security Number: [illegible]  
3. Date of birth: [illegible]  
4. Marital status: [illegible]  
5. Filing status: [illegible]  
6. Number of dependents: [illegible]  
7. Gross income: [illegible]  
8. Adjusted gross income: [illegible]  
9. Taxable income: [illegible]  
10. Federal income tax: [illegible]  
11. State income tax: [illegible]  
12. Total tax: [illegible]  
13. Refund: [illegible]  
14. Amount paid: [illegible]  
15. Balance due: [illegible]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Carney</i>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>X Carney</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>9223 Orbital Road</i>		d. STREET ADDRESS <i>1 9223 Orbital Road</i>	
3. NAME OF DECEASED (Type or print) <i>Mr. Gerard Joseph Rosenberger</i>		4. DATE OF DEATH Month <i>November</i> Day <i>25</i> Year <i>19 61</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Apr 18, 1894</i>
9. AGE (In years last birthday) <i>67</i> yrs.		10. AGE (In years last birthday) <i>67</i> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Butcher</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Food Fair</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>Baltimore, Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Peter A. Rosenberger</i>		14. MOTHER'S MAIDEN NAME <i>Maria Acker</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <i>214-03-0889</i>		16. SOCIAL SECURITY NO. <i>214-03-0889</i>	
17. INFORMANT <i>Mrs. Rose E. Rosenberger</i>		Address <i>same</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO <i>Cardiac Arrest</i> Conditions, if any, which gave rise to immediate cause (b) <i>Myocardial Infarction</i> (a), stating the underlying cause last. DUE TO (c) <i>Myotrophica atrophica</i>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Myotrophica atrophica</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (his hospital) attended the deceased from <i>1960</i> to <i>11/25</i> , 1961, that (I) (she) saw the deceased alive on <i>11/24</i> , 1961, and that death occurred at <i>8 A.M.</i> from the causes and on the date stated above.			
22a. SIGNATURE <i>Paul G. Mueller</i>		22b. DATE SIGNED <i>11/26/61</i>	
22c. PHYSICIAN'S NAME (Type) <i>Paul G. Mueller</i>		22d. ADDRESS <i>6411 Belair Rd Md.</i>	
23a. BURIAL, CREMATION, REMOVALS (Specify) <i>Burial</i>		23b. DATE THEREOF <i>12/28/61</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Holy Redeemer Cemetery</i>		23d. LOCATION (City, town or county) (State) <i>Baltimore, Maryland</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i>		25a. REC'D BY REGISTRAR <i>NOV 28 '61</i>	
25b. REGISTRAR'S SIGNATURE <i>Arthur S. Thoma</i>		25c. REGISTRAR'S SIGNATURE	



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

12386

13372

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> c. LENGTH OF STAY in lb <u>1mth26dys</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SPRING GROVE STATE HOSPITAL</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> <span style="float: right;">b. COUNTY <u>✓</u></span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <span style="float: right;"><u>3 v01-4</u></span> d. STREET ADDRESS <u>3910 Emmart Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Jack H. Rosenbloom</u> First Middle Last			<b>4. DATE OF DEATH</b> <u>November 9 19 61</u> Month Day Year				
<b>5. SEX</b> <u>male</u>		<b>6. COLOR OR RACE</b> <u>white</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
<b>8. DATE OF BIRTH</b> <u>June 10, 1906</u>		<b>9. AGE</b> (In years last birthday) <u>55</u> yrs. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> IF UNDER 24 HRS.: Hours <u>  </u> Min. <u>  </u>		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>pharmacist</u>			
<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>  </u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>England</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U. S. A.</u>			
<b>13. FATHER'S NAME</b> <u>Solomon Rosenbloom</u>			<b>14. MOTHER'S MAIDEN NAME</b> <u>Ida Schwlat</u>				
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>unknown</u> (If yes give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <u>unknown</u>		<b>17. INFORMANT</b> <u>Records: SPRING GROVE STATE HOSPITAL</u> Address			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> DUE TO (b) <u>Hypertensive cardiovascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>  </u>					<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>  </u>		
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>  </u>			
<b>20f. (City or town)</b> <u>  </u>		<b>(County)</b> <u>  </u>		<b>(State)</b> <u>  </u>			
<b>21. I certify</b> <del>that</del> <u>he</u> (this hospital) attended the deceased from <u>Sept. 13 1961</u> to <u>Nov. 9 1961</u> that <u>he</u> (we) last saw the deceased alive on <u>Nov. 9 1961</u> , and that death occurred at <u>a. M.</u> from the causes and on the date stated above.							
<b>22a. SIGNATURE</b> <u>Stella Wachslar</u> M.D.			<b>ATTENDING PHYS.</b> <input type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input checked="" type="checkbox"/> <u>11-9-61</u> <b>22b. DATE SIGNED</b>				
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>Stella Wachslar, M. D.</u>			<b>22d. ADDRESS</b> <u>SPRING GROVE STATE HOSPITAL</u> <u>Catonsville 28, Maryland</u>				
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>Nov 10/61</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Hebrew Young Men</u>			
<b>23d. LOCATION</b> (City, town or county) <u>Baltimore, Md.</u>		<b>(State)</b> <u>  </u>					
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Sol. Levinson &amp; Bros. Inc. 6010 Reist Rd.</u>			<b>25a. REC'D BY REGISTRAR</b> <u>NOV 13 '61</u> DATE				
<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Evans</u>			<b>25c. REGISTRAR'S SIGNATURE</b> <u>  </u>				

MEDICAL CERTIFICATION

TO HO...AL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

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RECEIVED

NOV 13 1951

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
FOR STATE  
HEALTH DEPT.

VS. A15ME  
SM 7/59

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
12387 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12373

1. PLACE OF DEATH a. COUNTY <u>Baltimore Co.</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>18 Yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Dundalk (Turners Station)</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>104 Carver Rd.</u>		d. STREET ADDRESS <u>201 Clinton Lane</u>	
3. NAME OF DECEASED (Type or print) <u>Fred Poindexter Russell</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>21</u> Year <u>19 61</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 12, 1912</u>
9. AGE (In years last birthday) <u>49 yrs.</u>		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sanitation Dept.</u>		11. BIRTHPLACE (State or foreign country) <u>Kannapolis North Carolina</u>	
12. CITIZEN OF WHAT COUNTRY? <u>  </u>		13. FATHER'S NAME <u>John Murray</u>	
14. MOTHER'S MAIDEN NAME <u>Irma Russell</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>  </u>	
16. SOCIAL SECURITY NO. <u>237-01-9881</u>		17. INFORMANT <u>Mrs. Edna Russell</u> Address <u>201 Clinton Lane</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>  </u> (c) DUE TO (e), stating the underlying cause last. <u>  </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) (County) (State) <u>  </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <u>M.B. Davis</u> M.D. <u>M.B. DAVIS M.D.</u> DEPUTY MEDICAL EXAMINER <u>  </u> Address (Street, city, town, or county) <u>  </u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-25-61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arbutus Mem. Park</u>		22d. LOCATION (City, town, or country) (State) <u>Arbutus, Md.</u>	
23. FUNERAL DIRECTOR <u>Wm. G. Jackson Inc.</u>		24a. REC'D BY REGISTRAR <u>NOV 24 '61</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>		DATE <u>  </u>	

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 7/59

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FOR STATE  
HEALTH DEPT.

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH  
12388 12374

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>MD.</b> b. COUNTY <b>BALTIMORE</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TOWSON</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TOWSON</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>957 FAIRMOUNT AVE</b>				d. STREET ADDRESS <b>957 FAIRMOUNT AVE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>WILSON DOUGLAS RUTHERFORD</b>		4. DATE OF DEATH <b>NOV. 25 1961</b>		5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8-24-10</b>		9. AGE (In years last birthday) <b>51</b> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>INSPECTOR</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>AUTO</b>		11. BIRTHPLACE (State or foreign country) <b>MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>OLIVER B RUTHERFORD</b>				14. MOTHER'S MAIDEN NAME <b>Mary Ellen Glenn</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. <b>WW 2-14246</b>		17. INFORMANT <b>MRS. RUTHERFORD</b>		Address <b>957 FAIRMOUNT</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b> <b>420.1</b> DUE TO (b) <b>CORONARY ARTERY DISEASE</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH <b>5 MIN</b> <b>2 YRS.</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While et work <input type="checkbox"/> Not While et work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>William A. Pillsbury</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>William A. Pillsbury</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <b>Timonick</b> and <b>And</b> DATE SIGNED <b>11-25-61</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>11-28-61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		22d. LOCATION (City, town, or country) (State) <b>Baltimore</b>	
23. FUNERAL DIRECTOR ADDRESS <b>Wm. Cook-Towson, Inc., 1050 York Road. Towson</b>				24a. REC'D BY REGISTRAR <b>NOV 28 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

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1877

REPORT OF THE MEDICAL EXAMINER

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
12389									
12375									
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>✓</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>					c. LENGTH OF STAY IN 1b <b>13 Days</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Veterans Administration Hospital</b>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>				
3. NAME OF DECEASED (Type or print) <b>ROBERT E. RYAN</b>					d. STREET ADDRESS <b>423 South Parrish Street</b>				
5. SEX <b>Male</b>					4. DATE OF DEATH <b>November 20 1961</b>				
6. COLOR OR RACE <b>White</b>					7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <b>May 4, 1895</b>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>					9. AGE (In years last birthday) <b>66 yrs. 6</b>				
10b. KIND OF BUSINESS OR INDUSTRY <b>Department Store</b>					11. BIRTHPLACE (County & State, or foreign country) <b>Allegany Co. Cumberland, Maryland</b>				
13. FATHER'S NAME <b>Francis E. Ryan</b>					12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW-1</b>					16. SOCIAL SECURITY NO. <b>WM-1</b>				
17. INFORMANT <b>Edith Obet</b>					Address <b>Clin Rec VAH Baltimore Md - Ft Howard Division</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RIGHT LOWER LOBE PNEUMONIA</b>									
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <b>CEREBRAL THROMBOSIS</b>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>ARTERIOSCLEROTIC HEART DISEASE; CONGESTIVE HEART FAILURE</b>									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>									
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>									
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)									
20f. (City or town) (County) (State)									
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Nov. 7, 1961 to Nov. 20, 1961</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Nov. 20, 1961</b> , and that death occurred at <b>4:06 p.m.</b> from the causes and on the date stated above.									
22a. SIGNATURE <b>John D. Talbert</b> M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22b. DATE SIGNED <b>11-20-61</b>									
22c. PHYSICIAN'S NAME (Type) <b>JOHN D. TALBERT M.D.</b> 22d. ADDRESS <b>VAH Baltimore Md - Ft Howard Division</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 23b. DATE THEREOF <b>11-23-61</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b> 23d. LOCATION (City, town or county) (State) <b>Baltimore Maryland</b>									
24. FUNERAL DIRECTOR'S SIGNATURE <b>Frederick A. Cole</b> ADDRESS <b>1913 W. Baltimore St Baltimore 23 Md</b> 25a. REC'D BY REGISTRAR <b>NOV 24 '61</b> 25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kane</b>									

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

12376

1  
 FOR STATE  
 HEALTH DEPT.

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hydes</u> c. LENGTH OF STAY in 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Maryland</u> f. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hydes</u> d. STREET ADDRESS <u>Church Lane</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>John Carl Schaeffer</u> First Middle Last		4. DATE OF DEATH <u>Nov. 4 1961</u> Month Day Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 26, 1884</u> 77 <sup>th</sup> birthday
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Trackman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Md. Pa. R.R.</u>	11. BIRTHPLACE (State or foreign country) <u>Baltimore County, Md</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>unknown</u>	
14. MOTHER'S MAIDEN NAME <u>unknown</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	
16. SOCIAL SECURITY NO. <u>705-10-8965</u>		17. INFORMANT <u>Mrs. Estella E. Schaefer, 1627 N. Calvert St</u> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) DUE TO (c) <u>422.1</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) ACTUAL SIGNATURE <u>R.S. Fisher MD</u> M.D. EXAMINER'S NAME (Type) <u>R.S. Fisher M.D.</u> DATE SIGNED <u>11/5/61</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>11-7-61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Trinity Episcopal Church Cem.</u>	22d. LOCATION (City, town, or country) (State) <u>Baltimore Co, Md</u>
23. FUNERAL DIRECTOR <u>Wm. Cook, Inc., 1217 St. Paul Street</u> ADDRESS		24a. REC'D BY REGISTRAR <u>NOV 7 '61</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. K...</u>



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12391 MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

12377

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN 1b <b>5mth23 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>				d. STREET ADDRESS <b>108 Shelly Road</b>			
3. NAME OF DECEASED (Type or print) First <b>Louis</b> Middle <b>Schmincke</b> Last <b>Schmincke</b>				4. DATE OF DEATH Month <b>November</b> Day <b>16</b> Year <b>1961</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 14, 1900</b>	
9. AGE (In years last birthday) <b>61</b> yrs.		IF UNDER 1 YEAR Months <b>02</b> Days <b>23</b>		IF UNDER 24 HRS. Hours <b>00</b> Min. <b>00</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>unknown</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>unknown</b>		11. BIRTHPLACE (State or foreign country) <b>unknown</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>unknown</b>				14. MOTHER'S MAIDEN NAME <b>unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>unknown</b>		17. INFORMANT <b>Records; SPRING GROVE STATE HOSPITAL</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Decompensatory and congestive heart failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Luetic heart disease</b> DUE TO (c) <b></b>				INTERVAL BETWEEN ONSET AND DEATH <b></b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <b>he</b> (this hospital) attended the deceased from <b>May 23, 1961</b> to <b>November 16, 1961</b> that (I) <b>he</b> last saw the deceased alive on <b>November 16, 1961</b> , and that death occurred at <b>7:05 AM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>H. I. Cholmondeley</b>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>11.16.61</b>	
22c. PHYSICIAN'S NAME (Type) <b>H. I. Cholmondeley</b>				22d. ADDRESS <b>SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11-20-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>Balto 25, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Mc Cully Funeral Home</b>				ADDRESS <b>150 E. Towson Rd. 50, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>NOV 20 '61</b>	
				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>			

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## CERTIFICATE OF DEATH

Reg. Dist. No. 12378

12392

1. PLACE OF DEATH o. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>BALTO</u>	
3a. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ENGLISH COUNSEL</u>		3b. LENGTH OF STAY IN 1b. <u>ENGLISH COUNSEL</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3808 ANNAPOLIS RD</u>		d. STREET ADDRESS <u>13808 ANNAPOLIS RD</u>	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>SCHNEIDER</u> Last <u>SCHNEIDER</u>		4. DATE OF DEATH Month <u>NOV</u> Day <u>5</u> Year <u>1961</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>27 FEB 1875</u>
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	IF UNDER 24 HRS. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>  </u>		10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>	11. BIRTH PLACE (State or foreign country) <u>HUNGARY</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>JOHN NEW</u>	
14. MOTHER'S MAIDEN NAME <u>ANNA NEW</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>  </u> (If yes, give war or dates of service) <u>  </u>	
16. SOCIAL SECURITY NO. <u>NONE</u>		INFORMANT <u>MRSC. P. TEE</u> Address <u>3808 ANNAPOLIS RD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis - recurrent</u> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>15 yrs</u> <u>17 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month <u>  </u> Day <u>  </u> Year <u>19</u> Hour o. m. <u>  </u> p. m. <u>  </u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>November 27, 1950</u> , to <u>November 5, 1961</u> , that I last saw the deceased alive on <u>November 3, 1961</u> , and that death occurred at <u>7:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>C. Arthur Rossberg</u> M.D.		ADDRESS (Street, city or town, state) <u>2436 Washington Blvd</u> DATE SIGNED <u>11/6/61</u>	
PHYSICIAN'S NAME (Type) <u>C. ARTHUR ROSSBERG</u>		<u>Baltimore 30, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>BURIAL</u>	<u>9 NOV 1961</u>	<u>HOLY CROSS</u>	<u>A.A. Co Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Goulson</u>		ADDRESS <u>739 Wash Blvd</u>	
24a. REC'D BY REGISTRAR <u>NOV 8 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

OFFICE OF THE SECRETARY OF THE ARMY

1893

(M)

Very respectfully,  
Your obedient servant,  
John M. Smith  
Major General  
United States Army  
Washington, D.C.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12393

## CERTIFICATE OF DEATH

12379

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Lansdowne</u> c. LENGTH OF STAY IN 1b <u>years?</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>3025 Freeway</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Lansdowne md.</u> d. STREET ADDRESS <u>3025 Freeway</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Robert</u> Middle <u>Schott</u> Last <u>Schott</u>				<b>4. DATE OF DEATH</b> Month <u>Nov</u> Day <u>22</u> Year <u>1961</u>							
<b>5. SEX</b> <u>male</u>		<b>6. COLOR OR RACE</b> <u>white</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>8/19/61</u>		<b>9. AGE</b> (In years last birthday) <u>3</u> yrs. IF UNDER 1 YEAR: Months <u>3</u> Days <u>3</u> IF UNDER 24 HRS.: Hours <u>3</u> Min. <u>3</u>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>child</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>none</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Baltimore</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>			
<b>13. FATHER'S NAME</b> <u>Robert Schott</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Helen Tripton</u>							
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u>				<b>16. SOCIAL SECURITY NO.</b> <u>no</u>		<b>17. INFORMANT</b> (Address) <u>Mr Robert Schott 3025 Freeway</u>					
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Viral Infection (Influenzal) with</u> <u>481X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Overwhelming Toxemia</u> cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Congenital Heart Disease Type undetermined</u>										<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.) _____ <b>20c. TIME OF INJURY</b> Month, Day, Year <u>19</u> Hour a.m. _____ p.m. _____ <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) _____ <b>20f. (City or town)</b> _____ <b>(County)</b> _____ <b>(State)</b> _____											
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>August 1961</u> , to <u>11/22</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>11/22</u> 19 <u>61</u> , and that death occurred at <u>6:50 PM</u> , from the causes and on the date stated above.											
<b>22a. SIGNATURE</b> <u>James N. Frederick</u>						<b>22b. DATE SIGNED</b> <u>11/22/61</u>		<b>22c. PHYSICIAN'S NAME</b> (Type) <u>J.N. Frederick MD</u>		<b>22d. ADDRESS</b> <u>1311 Francis Ave. Balto 27, Md</u>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>				<b>23b. DATE THEREOF</b> <u>11/24/61</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Belen Haven Cem.</u>				<b>23d. LOCATION</b> (City, town or county) <u>Pitchie Hgwy</u> <b>(State)</b> <u>md.</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>John J. Cowan &amp; Son Inc</u>						<b>25a. REC'D BY REGISTRAR</b> <u>Hollins St.</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Hume</u>		<b>DATE</b> <u>NOV 24 '61</u>	

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TO TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

20554

2521



12394

## CERTIFICATE OF DEATH

Reg. Dist. No.

12380

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Balto.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1329 Dillon Heights Ave.</u>		d. STREET ADDRESS <u>1329 Dillon Heights Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>Leo</u> Middle <u>V. Schroeder</u> Last <u>Sn.</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>5</u> Year <u>1961</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 13, 1901</u>
9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Gas &amp; Electric</u>	
11. BIRTHPLACE (State or foreign country) <u>md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Schroeder</u>		14. MOTHER'S MAIDEN NAME <u>MAY ?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-05-7410</u>	
17. INFORMANT Address <u>Mrs. Marie Schroeder - 1329 Dillon Heights</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular accident.</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>Atherosclerosis.</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>2 days.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1/2</u> , 19 <u>59</u> , to <u>11/5/61</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>11/3/61</u> , 19 <u>61</u> , and that death occurred at <u>8 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Milton Schleiff</u> M.D.		ADDRESS (Street, city or town, state) <u>6410 Windsor Mill Rd Balto Md</u>	
PHYSICIAN'S NAME (Type) <u>Milton Schleiff</u>		DATE SIGNED <u>4/6/61</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Nov. 9, 1961</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u>	22d. LOCATION (City, town, or county) (State) <u>Woodlawn md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John T. Stansbury</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 7 '61</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanes</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

(M)

1917

1. Name of deceased		2. Sex		3. Age		4. Date of death	
5. Place of death		6. Cause of death		7. Duration of illness		8. Name of physician	
9. Name of informant		10. Signature of informant		11. Signature of physician		12. Signature of registrar	
13. Name of registrar		14. Signature of registrar		15. Signature of physician		16. Signature of informant	
17. Name of physician		18. Signature of physician		19. Signature of informant		20. Signature of registrar	
21. Name of informant		22. Signature of informant		23. Signature of physician		24. Signature of registrar	
25. Name of registrar		26. Signature of registrar		27. Signature of physician		28. Signature of informant	
29. Name of physician		30. Signature of physician		31. Signature of informant		32. Signature of registrar	
33. Name of informant		34. Signature of informant		35. Signature of physician		36. Signature of registrar	
37. Name of registrar		38. Signature of registrar		39. Signature of physician		40. Signature of informant	
41. Name of physician		42. Signature of physician		43. Signature of informant		44. Signature of registrar	
45. Name of informant		46. Signature of informant		47. Signature of physician		48. Signature of registrar	
49. Name of registrar		50. Signature of registrar		51. Signature of physician		52. Signature of informant	
53. Name of physician		54. Signature of physician		55. Signature of informant		56. Signature of registrar	
57. Name of informant		58. Signature of informant		59. Signature of physician		60. Signature of registrar	
61. Name of registrar		62. Signature of registrar		63. Signature of physician		64. Signature of informant	
65. Name of physician		66. Signature of physician		67. Signature of informant		68. Signature of registrar	
69. Name of informant		70. Signature of informant		71. Signature of physician		72. Signature of registrar	
73. Name of registrar		74. Signature of registrar		75. Signature of physician		76. Signature of informant	
77. Name of physician		78. Signature of physician		79. Signature of informant		80. Signature of registrar	
81. Name of informant		82. Signature of informant		83. Signature of physician		84. Signature of registrar	
85. Name of registrar		86. Signature of registrar		87. Signature of physician		88. Signature of informant	
89. Name of physician		90. Signature of physician		91. Signature of informant		92. Signature of registrar	
93. Name of informant		94. Signature of informant		95. Signature of physician		96. Signature of registrar	
97. Name of registrar		98. Signature of registrar		99. Signature of physician		100. Signature of informant	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Overlea</b> c. LENGTH OF STAY IN 1b <b>23 Glenmore Ave.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>23 Glenmore Ave.</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Overlea</b> d. STREET ADDRESS <b>23 Glenmore Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Virgil T. Schultz</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>17</b> Year <b>1961</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 3, 1889</b>	
9. AGE (In years last birthday) <b>72</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Assemblyman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Aircraft</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Indiana</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Theodore Schultz</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Kretzmeier</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>305-05-0949A</b>	
17. INFORMANT <b>Mrs. Esther G. Schultz</b>		Address <b>23 Glenmore Ave. 6</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebro-Vascular accident</b> 160.2 DUE TO <b>Carcinoma Rt Antrum</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO <b>with Metastases</b> (e) <b>Diabetes mellitus</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Diabetes mellitus</b> INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>2 yrs</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 1, 1961</b> to <b>Nov 17, 1961</b> , that (I) (we) last saw the deceased alive on <b>Nov 17, 1961</b> , and that death occurred at <b>2:24 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>M. Baunyardner</b> 22c. PHYSICIAN'S NAME (Type)		22b. DATE SIGNED <b>11/17/61</b> 22d. ADDRESS <b>Balto 6 Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11-21-1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Fairland</b>		23d. LOCATION (City, town or county) (State) <b>Fairland, Indiana.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Lassahn Funeral Home</b>		25a. REC'D BY REGISTRAR DATE <b>NOV 20 '61</b>	
ADDRESS <b>7401 Belair Rd</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

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John J. Moore

Marjorie

John J. Moore

Quincy

Quincy

81 Diamond Ave.

81 Diamond Ave.

April

April

April

Miss Alice

Miss Alice

15

Assessment

Assessment

Assessment

Theresa Griffin

Theresa Griffin

100-10-1000 10. Town 1. School 23 Diamond Ave. 8

Attesty  
Notary Public  
in and for the State of New York  
County of New York  
City of New York  
I, the undersigned, Notary Public, do hereby certify that the foregoing is a true and correct copy of the original as the same appears from the records of the City of New York.

Notary, Indiana

Notary and

10-10-1001

Notary

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

12382

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>3001-4</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>62 Days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Veterans Administration Hospital</b>		d. STREET ADDRESS <b>1315 Brunt Street</b>	
3. NAME OF DECEASED (Type or print) <b>CHARLES H. SCOTT</b>		4. DATE OF DEATH Month <b>November</b> Day <b>28</b> Year <b>19 61</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 15, 1894</b>
9. AGE (In years last birthday) <b>67</b> yrs.		10. IF UNDER 1 YEAR Months <b>6</b> Days <b>13</b> Hours <b>4</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Gloucester Co., Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Charles H. Scott</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Burrell</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WW I</b>		16. SOCIAL SECURITY NO. <b>15-12-34567</b>	
17. INFORMATION <b>Clinical Records, VAH, Baltimore 18, Maryland</b> <b>FORT HOWARD DIVISION</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CARCINOMA OF THE ESOPHAGUS</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>CACHEXIA, EXTREME</b>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20. INTERVAL BETWEEN ONSET AND DEATH <b>RECENT</b> <b>UNKNOWN</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <b>10</b> (this hospital) attended the deceased from <b>Sept. 27, 1961</b> to <b>Nov. 28, 1961</b> , that <b>10</b> (we) last saw the deceased alive on <b>Nov. 28, 1961</b> , and that death occurred at <b>8:20 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Thomas F. Crahan</b>		22b. DATE SIGNED <b>11/29/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>THOMAS F. CRAHAN, M.D.</b>		22d. ADDRESS <b>VAH, BALTIMORE 18 MD., FT. HOWARD DIVISION</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-3-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore 28, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Elroy O. Wilson</b>		25. REC'D BY REGISTRAR <b>DEC 6 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Elroy O. Wilson</b>		25c. REGISTRAR'S NAME <b>Elroy O. Wilson</b>	

VR A15 (4)  
15M 9/60

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> <span style="float:right">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> <span style="float:right">b. COUNTY <u>Baltimore</u></span>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. LENGTH OF STAY IN 1b <u>1006 Concordia Drive</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Towson</u>		d. STREET ADDRESS <u>1006 Concordia Drive</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>1006 Concordia Drive</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Ruth</u> Middle <u>C.</u> Last <u>Selph</u>				<b>4. DATE OF DEATH</b> Month <u>Nov.</u> Day <u>27</u> Year <u>19 61</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 30, 1905</u>	9. AGE (In years last birthday) <u>56</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>		11. BIRTHPLACE (County & State, or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Samuel Baxter</u>				14. MOTHER'S MAIDEN NAME <u>Harriett Shauenessey</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes give war or dates of service)</u>		16. SOCIAL SECURITY NO. <u>216369775</u>		17. INFORMANT <u>Elgin W. Selph</u>		Address <u>same</u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchogenic Carcinoma</u> <u>162.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from <u>26 Aug. 1961</u> to <u>28 Nov. 61</u> , that (I) (we) last saw the deceased alive on <u>27 Nov. 1961</u> , and that death occurred at <u>12:25</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Amblewick</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>28 Nov 61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. Anderson M. Renick Jr.</u>				22d. ADDRESS <u>1101 St. Paul Street Balto. 2, Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>11-30-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Moreland Mem. Park</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>				ADDRESS <u>5305 Harford Rd.</u>		25a. REC'D BY REGISTRAR DATE <u>DEC 1 61</u>	
				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanks</u>			

1893

1893



Leonard R. Wood 707 Astor Ave.  
11-20-97  
1101 St. Paul Street  
Chicago, Ill.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
12398						12384					
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>				c. LENGTH OF STAY IN 1b <b>25 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Upperco</b>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Veterans Administration Hospital</b>						d. STREET ADDRESS <b>Trenton Road</b>			a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>HERBERT</b> Middle <b>E.</b> Last <b>SHAFFER</b>						4. DATE OF DEATH Month <b>November</b> Day <b>17</b> Year <b>1961</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 14, 1892</b>		9. AGE (In years last birthday) <b>69</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>William Shaffer</b>						14. MOTHER'S MAIDEN NAME <b>Mary E. Patterson</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>Yes WW-1</b>						16. SOCIAL SECURITY NO. <b>WW-1</b>			17. INFORMANT <b>Clin Rec VAH Baltimore Md - Ft Howard Division</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF THE COLON WITH METASTASIS</b> <b>153.8</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>October 23, 1961</b> to <b>November 17, 1961</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Nov. 17, 1961</b> , and that death occurred at <b>6:30 PM</b> , from the causes and on the date stated above.											
22a. SIGNATURE <b>Donald W. Stewart</b> M.D.						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22b. DATE SIGNED <b>11-17-61</b>		
22c. PHYSICIAN'S NAME (Type) <b>Donald W. Stewart</b> M.D.						22d. ADDRESS <b>VAH Baltimore Md - Ft Howard Division</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11-20-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Christ Church Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Upperco, B.D. Maryland</b>					
24. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph F. Eline &amp; Son</b>						ADDRESS <b>Main Street Reisterstown Md</b>		25a. REC'D BY REGISTRAR <b>NOV 21 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
15M 9/59

12399

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

12385

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pikesville</b>				c. LENGTH OF STAY IN 1b <b>X PIKESVILLE</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>7506 Slade Avenue</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>REBA</b> Middle <b>FLAX</b> Last <b>SHEAR</b>				4. DATE OF DEATH Month <b>NOVEMBER 8,</b> Day <b>19</b> Year <b>61</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>SEPTEMBER 12, 1900</b>	
9. AGE (In years lost birthday) <b>61</b> yrs.		10. IF UNDER 1 YEAR Months <b>61</b> Days <b>10</b> Hours <b>10</b> Min.		11. BIRTHPLACE (State or foreign country) <b>RUSSIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>			
13. FATHER'S NAME <b>MICHAEL RESNICK</b>				14. MOTHER'S MAIDEN NAME <b>MINNIE PLATT</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>				16. SOCIAL SECURITY NO. <b>NO</b>			
17. INFORMANT <b>MRS. MICKEY BLIDEN- 7506 SLADE AVENUE</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral and Osseous Metastases</b> 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Carcinoma of breast</b> DUE TO (c) <b>10 years</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>2 years</b> INTERVAL BETWEEN ONSET AND DEATH							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>5/12 1960 to 11/8 1961</b>				20g. (County) <b>BALTIMORE</b>		20h. (State) <b>MARYLAND</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>5/12 1960</b> to <b>11/8 1961</b> , that (I) (we) last saw the deceased alive on <b>11/8 1961</b> , and that death occurred at <b>8 A.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Alan Bernstein</b>				22b. ADDRESS <b>819 Park Ave Balt Md</b>			
22c. PHYSICIAN'S NAME (Type) <b>Alan Bernstein, M.D.</b>				22d. ADDRESS <b>819 Park Ave Balt Md</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>				23b. DATE THEREOF <b>Nov 9/61</b>			
23c. NAME OF CEMETERY OR CREMATORY <b>GREATER BALTIMORE LODGE</b>				23d. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>SOL. LEVINSON &amp; BROS. INC. 6010 Reist Road</b>				25a. REC'D BY REGISTRAR <b>DATE NOV 13 '61</b>			
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>				25c. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be filed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>✓</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		c. LENGTH OF STAY IN 1b <b>1 yr.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Mercy Villa-Bellona Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Elizabeth</b> Middle <b>Turnbull</b> Last <b>Shoemaker</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>24</b> Year <b>19 61</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-9-1871</b>
9. AGE (In years last birthday) <b>90</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Nisbet Turnbull</b>		14. MOTHER'S MAIDEN NAME <b>Olivia Whitridge</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>--</b>	
17. INFORMANT <b>Records of Mercy Villa</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Aspiration pneumonia, chronic,</b> <b>334X</b> DUE TO <b>due to pseudobulbar palsy,</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>due to cerebral arteriosclerosis,</b> (c) <b>severe</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b> <b>6 months</b> <b>at least 8 years</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <b>(this hospital)</b> attended the deceased from <b>Oct 1959</b> to <b>Nov. 1961</b> , that (I) (we) last saw the deceased alive on <b>Nov 17, 1961</b> , and that death occurred at <b>2p. M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>W.B. Daniels, Jr.</b>		22b. DATE SIGNED <b>11/25/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>W. B. Daniels, Jr.</b>		22d. ADDRESS <b>11 E. Chase St. (#2)</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11-27-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>St. Thomas'</b>		23d. LOCATION (City, town, or county) (State) <b>Garrison Forest Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>H.W. Jenkins &amp; Sons Co.</b>		25a. REC'D BY REGISTRAR <b>NOV 28 61</b>	
ADDRESS <b>4905 York Road Balto. 12, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Wm. S. Kraus</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12401

## CERTIFICATE OF DEATH

12387

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> <b>MARYLAND</b>			<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>—</u>		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore -18</u>		
c. LENGTH OF STAY IN 1b <u>63 days</u>			d. STREET ADDRESS <u>3206 Loch Raven Road</u>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Veterans Administration Hospital</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
<b>3. NAME OF DECEASED</b> (Type or print) First <u>NATHAN</u> Middle <u>—</u> Last <u>SILBERMAN</u>			<b>4. DATE OF DEATH</b> Month <u>November</u> Day <u>7</u> Year <u>19 61</u>		
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
<b>8. DATE OF BIRTH</b> <u>January 15, 1896</u>		<b>9. AGE</b> (In years last birthday) <u>65</u> yrs.		<b>10. IF UNDER 1 YEAR</b> Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Insurance Agent</u>			<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Life Insurance Co.</u>		
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Baltimore, Maryland</u>			<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>		
<b>13. FATHER'S NAME</b> <u>Abraham Silberman</u>			<b>14. MOTHER'S MAIDEN NAME</b> <u>Sarah Stern</u>		
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>Yes</u> (If yes, give year or dates of service) <u>WW-1</u>			<b>16. SOCIAL SECURITY NO.</b> <u>212-01-7825</u>		
<b>17. INFORMANT</b> <u>Clinical Records</u> Address <u>VAH 3900 Loch Raven Blvd. Bal to 18, Md.</u>			<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).)		
<b>18a. PART I. DEATH WAS CAUSED BY:</b> IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE, CHRONIC</u> DUE TO <u>420.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO <u>—</u> (c) <u>—</u>			<b>18b. INTERVAL BETWEEN ONSET AND DEATH</b> <u>Unknown</u> <u>Unknown</u>		
<b>18c. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <u>Pulmonary Emphysema.</u>					
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>			<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)		
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>—</u> p.m. <u>19</u>			<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)			<b>20f. (City or town)</b> (County) (State)		
<b>21. I certify that</b> <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>Sept. 5, 1961</u> , to <u>Nov. 7, 1961</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>Nov. 7, 1961</u> , and that death occurred at <u>8:45 P.M.</u> , from the causes and on the date stated above.					
<b>22a. SIGNATURE</b> <u>Charles E. Rowan</u> M.D.			<b>22b. DATE SIGNED</b> <u>11/7/61</u>		
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>CHARLES E. ROWAN, M.D.</u>			<b>22d. ADDRESS</b> <u>VAH, Baltimore 18, Md-FORT HOWARD DIVISION</u>		
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>BURIAL</u>			<b>23b. DATE THEREOF</b> <u>11-10-61</u>		
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Baltimore National Cemetery</u>			<b>23d. LOCATION</b> (City, town or county) (State) <u>Baltimore Maryland</u>		
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Jack Lewis, Inc.</u>			<b>25a. REC'D BY REGISTRAR</b> <u>Nov 9 '61</u>		
<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kline</u>					

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Jack Lewis, Inc.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

12402

12388

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville, Md.</u> c. LENGTH OF STAY IN 1b <u>1</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>4 August Avenue</u>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Catonsville</u> d. STREET ADDRESS <u>4 August Avenue #28</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Thomas E. Sinclair</u>		4. DATE OF DEATH Month Day Year <u>November 25, 1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 15 1880</u>
9. AGE (In years last birthday) <u>81</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Supervisor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore Transit</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>George Sinclair</u>		14. MOTHER'S MAIDEN NAME <u>Rowenna Harrison</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-01-3633</u>	
17. INFORMANT <u>Mrs. Jane Musacchio</u>		Address <u>4 August Avenue</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY HEART DISEASE</u> DUE TO (b) <u>ARTERIO SCLEROTIC PROPO-UNSCOUR</u> DISEASE (c) <u>PELLAGRA EMPHYSEMA</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>INTERVAL BETWEEN ONSET AND DEATH</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>11/1</u> , 19 <u>61</u> , to <u>11/25</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>11/25</u> , 19 <u>61</u> , and that death occurred at <u>6:10 P.M.</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>John H. Shaw</u> M.D.		22b. DATE SIGNED <u>11/27/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN H. SHAW M.D.</u>		22d. ADDRESS <u>5800 EDMONDSON AVE. BALDWIN, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>11-28-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Jackson &amp; Sons Baltimore 17, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 28 '61</u>	
		25b. REGISTRAR'S SIGNATURE <u>William S. Thomas</u>	

MEDICAL CERTIFICATION

TO HOSTEL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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CERTIFICATE OF DEATH

Reg. Dist. No. 12403

1. PLACE OF DEATH a. COUNTY <b>Balto.</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Halethrope</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Halethrope</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>4313 Washington Blvd.</b>		d. STREET ADDRESS <b>4313 Washington Blvd.</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>IDA SMITH</b>		4. DATE OF DEATH Month Day Year <b>NOV. 7, 1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Col.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 18, 1879</b>
9. AGE (In years last birthday) <b>82</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Newburg Va.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Louis Jordon</b>		14. MOTHER'S MAIDEN NAME <b>Sallie Rend</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Benjamin Smith</b>		Address <b>4313 Washington Blvd.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the <u>under</u> lying cause last. (b) <b>Hypertensive Arteriosclerosis</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>15 Days</b> <b>?</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Oct. 23rd, 1961, to Nov. 7th, 1961</b> , that I last saw the deceased alive on <b>Nov. 7th, 1961</b> , and that death occurred at <b>9.00P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>C. F. Maloney, M.D.</b>		ADDRESS (Street, city or town, state) <b>57 Winters Lane</b>	
PHYSICIAN'S NAME (Type) <b>C. F. Maloney, MD.</b>		DATE SIGNED <b>10/7/61</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 11/61</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Auburn Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Mrs. Tatie R. Williams</b>		ADDRESS <b>322 N. Schroeder St.</b>	
24a. REC'D BY REGISTRAR <b>NOV 13 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

125403

1. NAME OF DECEASED WILLIAM		2. SEX Male	
3. AGE 45		4. DATE OF BIRTH 1910	
5. PLACE OF BIRTH Washington D.C.		6. OCCUPATION Teacher	
7. MARITAL STATUS Married		8. CAUSE OF DEATH Heart Disease	
9. PLACE OF DEATH Home		10. DATE OF DEATH 1955	
11. SIGNATURE OF DECEASED		12. SIGNATURE OF WITNESS	
13. SIGNATURE OF PHYSICIAN		14. SIGNATURE OF CORONER	
15. SIGNATURE OF REGISTRAR		16. SIGNATURE OF CLERK	
17. SIGNATURE OF JUDGE		18. SIGNATURE OF SHERIFF	
19. SIGNATURE OF DISTRICT ATTORNEY		20. SIGNATURE OF COUNTY CLERK	
21. SIGNATURE OF STATE CLERK		22. SIGNATURE OF SECRETARY OF HEALTH	
23. SIGNATURE OF BALTIMORE CLERK		24. SIGNATURE OF BALTIMORE CLERK	
25. SIGNATURE OF BALTIMORE CLERK		26. SIGNATURE OF BALTIMORE CLERK	
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79. SIGNATURE OF BALTIMORE CLERK		80. SIGNATURE OF BALTIMORE CLERK	
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89. SIGNATURE OF BALTIMORE CLERK		90. SIGNATURE OF BALTIMORE CLERK	
91. SIGNATURE OF BALTIMORE CLERK		92. SIGNATURE OF BALTIMORE CLERK	
93. SIGNATURE OF BALTIMORE CLERK		94. SIGNATURE OF BALTIMORE CLERK	
95. SIGNATURE OF BALTIMORE CLERK		96. SIGNATURE OF BALTIMORE CLERK	
97. SIGNATURE OF BALTIMORE CLERK		98. SIGNATURE OF BALTIMORE CLERK	
99. SIGNATURE OF BALTIMORE CLERK		100. SIGNATURE OF BALTIMORE CLERK	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be completed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G303 12/26/61 mh

CERTIFICATE OF DEATH

Reg. Dist. No. 12390

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>✓</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Villa Nova</b>		c. LENGTH OF STAY IN 1b <b>3 Yrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Augsburg Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>John Jacob</b> Middle <b>Spangler</b> Last <b></b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>26,</b> Year <b>1961</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 7, 1876</b>
9. AGE (In years last birthday) <b>84 85 yrs.</b>		10. IF UNDER 1 YEAR Months <b></b> Days <b></b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b></b>	
13. FATHER'S NAME <b>Andrew</b>		14. MOTHER'S MAIDEN NAME <b>? Lentz</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>***</b>	
17. INFORMANT <b>Records Augsburg Home</b>		Address <b>6811 Campfield</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>(1) - Broncho-Pneumonia</b> DUE TO <b>491X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>(2) - Arterio Sclerotic Heart Disease</b> DUE TO <b></b> (c) <b></b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 days - 6 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Generalized Arterio Sclerosis</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b></b>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m. <b></b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b></b>		20f. (City or town) (County) (State) <b></b>	
21. I certify that I attended the deceased from <b>Nov. 1st, 1961</b> to <b>Nov. 26, 1961</b> , that I last saw the deceased alive on <b>Nov. 25, 1961</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Earl L. Chambers</b>		DATE <b>4108 Liberty St. Balt. 7-11-27-61</b>	
PHYSICIAN'S NAME (Type) <b>Earl L. Chambers</b>		DATE <b>DEC 1 1961</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 29 61</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Immanuel</b>		22d. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. Heumann</b>		ADDRESS <b>6067 Harford Rd.</b>	
24a. REC'D BY REGISTRAR <b>DEC 1 1961</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	

12104

(M)

Belmont

Ville Nova

Adventure Home

John Jacob Bond

Sept. 1, 1970

Baltimore, Md.

Relief

Andrew

Adventure Home 6111

6001 National Dr.  
Baltimore, Md. 21204

12405

## CERTIFICATE OF DEATH

Reg. Dist. No. 12391

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL- ROSEDALE</b>		c. LENGTH OF STAY IN 1b <b>8 Years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>415 POTOMAC AVE.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>PEARL</b> Middle <b>T. STARKLAUF</b> Last		4. DATE OF DEATH Month <b>NOVEMBER 9,</b> Day <b>1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 4, 1904</b>
9. AGE (In years last birthday) <b>57</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>? Mueller</b>		14. MOTHER'S MAIDEN NAME <b>Sophia ?</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
INFORMANT <b>Samuel B. Starklauf</b>		Address <b>415 Potomac Ave. Zone 6</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Sclera. Degenera</b> <b>4222</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cardio-vascular disease</b> DUE TO (c) <b>Myocardial Infarction</b>			INTERVAL BETWEEN ONSET AND DEATH <b>11 mo</b> <b>7 mo</b> <b>10 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE, CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Oct 18, 1960</b> , to <b>11-9, 1961</b> , that I last saw the deceased alive on <b>11-9, 1961</b> , and that death occurred at <b>1 P. M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Daniel Miller</b>		ADDRESS (Street, city or town, state) <b>4321 Harford Rd</b>	
PHYSICIAN'S NAME (Type) <b>Daniel Miller M.D.</b>		DATE SIGNED <b>4321 Harford Rd</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Nov. 13, 1961</b>	22c. NAME OF CEMETERY <b>St. Paul's Fifth Ref. Ch.</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Philip E. Cvach</b>		24a. REC'D BY REGISTRAR <b>NOV 14 '61</b>	
ADDRESS <b>1211 Chesaco Ave. Zone 6.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13405

CENTRE CASE OF DEATH

13404

REMARKS

REMARKS

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may be filed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

**12406**

**12393**

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <span style="float:right">MARYLAND</span>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> <span style="float:right">b. COUNTY <b>Baltimore</b></span>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore (Pikesville)</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore, (Pikesville)</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>3226 Smith Avenue</b>				d. STREET ADDRESS <b>3226 Smith Avenue</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print)		First <b>PEARL</b>		Middle <b>YETTA</b>		Last <b>SUSSMAN</b>	
4. DATE OF DEATH		Month <b>19</b> Day <b>19</b> Year <b>61</b>		November <b>19</b> , 19 <b>61</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1888</b>	9. AGE (In years lost birthday) <b>73</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (State or foreign country) <b>Russia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Joseph Morris</b>				14. MOTHER'S MAIDEN NAME <b>Pesi ?</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>		17. INFORMANT <b>Mrs. Mae Gross- 3226 Smith Avenue</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>450.0 Congestive heart failure</b> DUE TO <b>Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>3 weeks</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1960</b> to <b>Nov. 19, 1961</b> , that (I) (we) last saw the deceased alive on <b>17 Nov 1961</b> , and that death occurred at <b>8:45 A.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Louis P. Hamburger for</b>				22b. DATE SIGNED <b>Nov 19, 1961</b>		22c. PHYSICIAN'S NAME (Type) <b>Louis P. Hamburger Sr.</b>	
22d. ADDRESS <b>1001 St Paul St. Baltimore 2, Md.</b>				22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Nov 20/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Har Zion Tifereth Israel</b>		23d. LOCATION (City, town, or county) (State) <b>Rosedale, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Sol. Levinson &amp; Bros. Inc. 6010 Reist Road</b>				25a. REC'D BY REGISTRAR <b>NOV 22 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Clinton L. House</b>	

12345

CERTIFICATE OF DEATH

12345

(M)

MADE IN U.S.A.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

MEDICAL CERTIFICATION

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
12407 CERTIFICATE OF DEATH 12394											
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 7</b>				c. LENGTH OF STAY IN 1b <b>9 1/2 yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 7</b>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>3208 St. Lukes Lane</b>						d. STREET ADDRESS <b>3208 St. Lukes Lane</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Mrs. Erma K. Thomas</b>						4. DATE OF DEATH Month Day Year <b>Nov. 10 19 61</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 1, 1892</b>		9. AGE (In years last birthday) yrs. Months Days <b>69</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cafeteria</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>C &amp; P Telephone Co.</b>				11. BIRTHPLACE (County & State, or foreign country) <b>Washington Co., Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Wm. Henry Knadler</b>						14. MOTHER'S MAIDEN NAME <b>Alice C. Thornberg</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>215-18-3836A</b>		17. INFORMANT <b>Mr. Eugene C. Uhler, 3208 St. Lukes Lane Balto. 7, Maryland</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of stomach with metastases</b> <b>151X</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. } DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>6 Months</b>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <b>4/1/61</b> to <b>11/10/61</b> , that (I) (we) last saw the deceased alive on <b>11/8/61</b> , and that death occurred at <b>2:55 PM</b> , from the causes and on the date stated above.											
22a. SIGNATURE <b>Edwin Pierpont</b>						M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>11/13/61</b>			
22c. PHYSICIAN'S NAME (Type) <b>Dr. Edwin Pierpont</b>						22d. ADDRESS <b>8204 Liberty Rd. Balto. 7, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>11/13/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Western Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore, Maryland</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Leung Byers</b>						ADDRESS <b>8728 Liberty Road Randallstown, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>NOV 14 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

(M)

(1)

12407

12394

Serial 11 12 13

STATE DEPARTMENT  
WASHINGTON, D.C.

Dr. John H. Thompson

8800 Liberty St., Detroit, Mich.

Bellevue, Michigan

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
12408						12395					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)					
a. COUNTY <b>Baltimore</b>						b. COUNTY <b>Maryland</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 17</b>					
c. LENGTH OF STAY IN 1b <b>2 Days</b>						d. STREET ADDRESS <b>2541 McCulloh Street</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Veterans Administration Hospital</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)						4. DATE OF DEATH					
First Middle Last <b>BENJAMIN TILLMAN</b>						Month Day Year <b>November 8 19 61</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>December 31, 1888</b>		9. AGE (In years last birthday) <b>72 yrs.</b>		IF UNDER 1 YEAR Months Days <b>72</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Steel</b>				11. BIRTHPLACE (County & State, or foreign country) <b>Wadesboro, N. Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Benjamin Tillman</b>						14. MOTHER'S MAIDEN NAME <b>Mary Marshall</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>						16. SOCIAL SECURITY NO. <b>213-09-0016</b>					
17. INFORMANT <b>Clinical Records, VAH, Baltimore 18, Maryland</b>						18. ADDRESS <b>FORT HOWARD DIVISION</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PULMONARY EDEMA</b>											
502.0 DUE TO <b>COR PULMONALE</b>											
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO <b>CHRONIC OBSTRUCTIVE EMPHYSEMA AND CHRONIC BRONCHITIS</b>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State) <b>November 6, 1961, to November 8, 1961, that (x) (we) last saw the deceased alive on Nov. 8, 1961, and that death occurred at 6:10 P.M. from the causes and on the date stated above.</b>		
21. I certify that (x) (this hospital) attended the deceased from <b>November 6, 1961, to November 8, 1961, that (x) (we) last saw the deceased alive on Nov. 8, 1961, and that death occurred at 6:10 P.M. from the causes and on the date stated above.</b>						22a. SIGNATURE <b>Thomas F. Crahan M.D.</b>					
22b. DATE SIGNED <b>11/9/61</b>						22c. PHYSICIAN'S NAME (Type) <b>THOMAS F. CRAHAN, M.D.</b>					
22d. ADDRESS <b>VAH, BALTO. 18, MD. FORT HOWARD DIVISION</b>						22e. ADDRESS <b>Balto. 17, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>11-13-61</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cemetery Baltimore</b>			
23d. LOCATION (City, town or county) (State) <b>28, Maryland</b>				24. FUNERAL DIRECTOR'S SIGNATURE <b>Elroy O. Wilson Funeral Home, 1000 Brantley Ave.</b>				25a. REC'D BY REGISTRAR <b>NOV 20 '61</b>			
25b. REGISTRAR'S SIGNATURE <b>William S. Thomas</b>											

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be completed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

12409

12396

1. PLACE OF DEATH a. COUNTY <b>Baltimore County</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEORGE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Wilson, Maryland</b>		c. LENGTH OF STAY IN 1b <b>2 1/2 mo.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Mt. Wilson State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>WILLIAM DAVID TIPTON</b>		4. DATE OF DEATH Month Day Year <b>NOVEMBER 23 1961</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>AUG. 9 1884</b>
9. AGE (In years last birthday) <b>77</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>BOILER FIREMAN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>VARIOUS BOILERS</b>	
11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JOHN TIPTON</b>		14. MOTHER'S MAIDEN NAME <b>MARTHA McCLELLAND</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>228-10-9480</b>	
17. INFORMANT <b>Hospital Records, Mt. Wilson State Hospital</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PULMONARY TUBERCULOSIS</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>PNEUMONOCOCCUS</b> (c) <b>Uncertain</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 YEARS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>SENILITY</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>9/11</b> to <b>11/23</b> 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>11/23</b> 19 <b>61</b> , and that death occurred at <b>1030 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Wm. Newcomer</b>		22b. DATE SIGNED <b>11/23/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Wm. Newcomer, M.D., Superintendent</b>		22d. ADDRESS <b>Mt. Wilson State Hospital, Mt. Wilson, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Nov. 26, 1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Maplewood Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Tazewell, Virginia</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>James D. Dally</b>		25a. REC'D BY REGISTRAR <b>WASH</b>	
25b. REGISTRAR'S SIGNATURE <b>254 Campbell St. N.W.</b>		DATE <b>NOV 27 '61</b>	

15201

WASHINGTON, D.C. 20540  
U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE  
BUREAU OF VITAL STATISTICS  
15201

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1883

1883



Washington  
D.C.

Right and Left, 200 Broadway Avenue (North of 210 St. Beachside)

Dec. 2, 1883  
77

U.S.A.

Joseph E. Tracy  
1. Carlton Street 33rd Avenue Road, Baltimore

Dear Sir:

I have received your letter of the 21st inst.

and am glad to hear that you are

interested in the work of the

Commission.

I am, Sir, very respectfully,

Yours, very truly,

John A. B. Jones

Secretary of the Commission

on the subject of the

Navigation of the

St. Lawrence River

John A. B. Jones  
Secretary of the Commission  
on the subject of the  
Navigation of the  
St. Lawrence River

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodlawn</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodlawn</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6407 Maple Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Edith C. Tyson</u>		4. DATE OF DEATH <u>Nov. 14 1961</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 18, 1869</u>
9. AGE (In years last birthday) <u>92</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Freeland, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Zimmerman</u>		14. MOTHER'S MAIDEN NAME <u>Rachel Ruhl</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Geo. Luers</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u> <u>10 years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>*****</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>am</u> <u>*****</u> 19 p. m.		20d. INJURY OCCURRED While <u>Not while</u> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>*****</u>		20f. (City or town) (County) (State) <u>*****</u>	
21. I certify that (I) <u>physician</u> attended the deceased from <u>19 50</u> to <u>November 19 61</u> that (I) <u>yes</u> last saw the deceased alive on <u>November 14 19 61</u> , and that death occurred at <u>9:45P</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Millard T. Traband, Jr.</u>		22b. DATE SIGNED <u>11/14/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Millard T. Traband, Jr.</u>		22d. ADDRESS <u>5101 Gwynn Oak Ave. Baltimore, 7, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11/17/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. John's</u>		23d. LOCATION (City, town, or county) (State) <u>New Freedom Pa.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John T. Stansbury</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 17 '61</u>	
ADDRESS <u>6411 Windsor M. '11 Rd.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kruse</u>	

CERTIFICATE OF MARRIAGE

12112

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I do hereby certify

that the within and foregoing

is a true and correct copy

of the original as the same appears in the records of the

II

WITNESSED BY ME

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NOTARY

in presence of

Witnesses

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12/1/11



12410 MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

12397

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>				c. LENGTH OF STAY IN 1b <b>5 years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>805 Scarlett Drive</b>				d. STREET ADDRESS <b>805 Scarlett Drive</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>August</b> Middle <b>Roland</b> Last <b>Tischinger</b>				4. DATE OF DEATH Month <b>November</b> Day <b>30</b> Year <b>1961</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3-22-1915</b>	
9. AGE (In years last birthday) <b>46</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Tool Making</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>August Robert Tischinger</b>				14. MOTHER'S MAIDEN NAME <b>Mabel Elizabeth Skillman</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>212-10-9606</b>		17. INFORMANT Address <b>Mr. Edw. Huber, 805 Scarlett Dr.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of transverse Colon</b> DUE TO <b>153.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c) INTERVAL BETWEEN ONSET AND DEATH							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Baltimore</b>				20g. (County) <b>Baltimore</b>		20h. (State) <b>Md.</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>August 1960</b> to <b>Nov 30 1961</b> , that (I) (we) last saw the deceased alive on <b>Nov. 27 1961</b> , and that death occurred at <b>3 P.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Warfield M Firor</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>Nov 30 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>WARFIELD M FIROR</b>				22d. ADDRESS <b>5101 Calvert St Balto</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-4-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Govans Presbyterian Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Henry W. Jenkins &amp; Sons</b>				25a. REC'D BY REGISTRAR <b>4905 York Road Balt. 12, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>DATE 5 '61</b>	

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**MARYLAND STATE DEPARTMENT OF HEALTH**  
**Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

**12400**

**FOR STATE HEALTH DEPT.**

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any day is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middlebough</u> c. LENGTH OF STAY IN 1b <u>X</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1800 Hilltop Ave.</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middlebough</u> d. STREET ADDRESS <u>1800 Hilltop Ave.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>3. NAME OF DECEASED</b> (Type or print) <u>George Frank Vanik</u>				<b>4. DATE OF DEATH</b> <u>Nov, 12 1961</u>											
<b>5. SEX</b> <u>male</u>		<b>6. COLOR OR RACE</b> <u>white</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>7/12/19 01</u>									
<b>9. AGE</b> (In years last birthday) <u>60</u> yrs. <table border="1"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.						
IF UNDER 1 YEAR		IF UNDER 24 HRS.													
Months	Days	Hours	Min.												
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Millwright</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Webb Fly Screen Co.</u>				<b>11. BIRTHPLACE</b> (State or foreign country) <u>Balto. Md.</u>							
<b>12. CITIZEN OF WHAT COUNTRY?</b>				<b>13. FATHER'S NAME</b> <u>Frank Vanik</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Frances Kurdna</u>							
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown)				<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> <u>George L. Vanik, son,</u>		<b>Address</b> <u>2521 Wentworth Rd.</u> <b>Zone</b> <u>14</u>							
<b>18. CAUSE OF DEATH</b> [Enter only one cause pertaining for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>DROWNING</u> <u>929.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>None</u> DUE TO (c)								<b>INTERVAL BETWEEN ONSET AND DEATH</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>								<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.</b>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>Was fishing &amp; fell overboard = (on pier)</u>											
<b>20c. TIME OF INJURY</b> <u>9:30 a.m. 11/12/61</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office, etc.) <u>Middle River</u>		<b>20f. (City or town)</b> <u>Essex</u>		<b>(County)</b> <u>21-Dawson</u> <b>(State)</b> <u>Md.</u>							
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from:</b> Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
<b>ACTUAL SIGNATURE</b> <u>M.B. Davis</u>				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>											
<b>EXAMINER'S NAME</b> (Type) <u>M.B. Davis M.D.</u>				<b>M.D. ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>				<b>DATE SIGNED</b> <u>11/12/61</u>							
<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>				<b>Address</b> (Street, city, town, or county)											
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>11/15/61</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Molv. Redeemer Cem.</u>		<b>22d. LOCATION</b> (City, town, or country) <u>Baltimore, Md.</u>		<b>(State)</b>							
<b>23. FUNERAL DIRECTOR</b> <u>Schimunek Funeral Home, Inc.</u> <u>2601 E. Madison St.</u>				<b>24a. REC'D BY REGISTRAR</b> <b>DATE</b> <u>NOV 14 '61</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Finney</u>									

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If 24 hours after death, it may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

12414

12401

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>		c. LENGTH OF STAY IN 1b <u>X</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>		d. STREET ADDRESS <u>8230 Laurel Drive</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>8230 Laurel Drive</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Charles</u> Middle <u>Vazzana</u> Last <u>Vazzana</u>				<b>4. DATE OF DEATH</b> Month <u>11</u> Day <u>30</u> Year <u>1961</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 23, 1889</u>	
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months <u>72</u> Days <u>11</u>		IF UNDER 24 HRS. Hours <u>19</u> Min. <u>61</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Barber</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Italy</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Lorenzo Vazzana</u>				14. MOTHER'S MAIDEN NAME <u>Rosalie Maggione</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes give year or dates of service)</u>		16. SOCIAL SECURITY NO. <u>216-28-8799</u>		17. INFORMANT <u>Mrs. Mary V. Vazzana</u>		Address <u>same</u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1</u> DUE TO <u>Arteriosclerosis CVD</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>15 Feb</u> to <u>30 Nov</u> , 19 <u>61</u> , that (I) ( <del>we</del> ) last saw the deceased alive on <u>30 Nov</u> , 19 <u>61</u> , and that death occurred at <u>2 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Howard Goodman</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Howard Goodman</u>				22d. ADDRESS <u>4604 Harford Rd</u>		<u>Baltimore (14) Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12/4/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>				ADDRESS <u>5305 Harford Rd.</u>		25a. REC'D BY REGISTRAR DATE <u>DEC 4 '61</u>	
				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

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Leonard J. New 505 Jackson St.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12415

CERTIFICATE OF DEATH

Item 3 Film G300 11/14/61 iwk

12402

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>8659 Hoerner Ave.</u>		d. STREET ADDRESS <u>8659 Hoerner Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>Anthony J. Velenovsky</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>3</u> Year <u>1961</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-14-1908</u>
9. AGE (In years last birthday) <u>53</u> yrs.		10. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>MATTHEW Velenovsky</u>		14. MOTHER'S MAIDEN NAME <u>FRANCES (LAST NAME NOT KNOWN)</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO. <u>215-01-8568</u>	
17. INFORMANT <u>Adeline V. Velenovsky</u>		Address <u>SAME</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Viral Staphylococcus Pneumonia</u> 492X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>VIRUS Pneumonia</u> (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u> <u>15 days</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (the hospital) attended the deceased from <u>Oct 17</u> , 19 <u>61</u> , to <u>Nov 3</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>Nov 3</u> , 19 <u>61</u> , and that death occurred at <u>11:30</u> A.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Michael J. Grossfeld</u>		22b. DATE SIGNED <u>11-3-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>MICHAEL J. GROSSFELD M.D.</u>		22d. ADDRESS <u>5407 Balis Rd. - Balto Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>11/6/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>BALTIMORE Cem.</u>	23d. LOCATION (City, town or county) (State) <u>BALTIMORE Md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		25a. REC'D BY REGISTRAR <u>NOV 7 '61</u>	
ADDRESS <u>5305 Harford Rd.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be signed by the attending physician and completely filled in by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12416

CERTIFICATE OF DEATH

Items 8 & 9 Film G301 11/29/61 wk 12403

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				d. STREET ADDRESS <b>414 Forest Ave.</b>			
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>J.</b> Last <b>Wagner</b>				4. DATE OF DEATH Month <b>November</b> Day <b>14</b> Year <b>1961</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1884</b>	
9. AGE (In years last birthday) <b>77</b>		IF UNDER 1 YEAR Months <b>11</b> Days <b>14</b>		IF UNDER 24 HRS. Hours <b>19</b> Min. <b>61</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>National Plastic Co.</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY <b>U.S.</b>							
13. FATHER'S NAME <b>Frank Wagner</b>				14. MOTHER'S MAIDEN NAME <b>Mary Koester</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>368-09-8866</b>			
17. INFORMANT <b>J. Donald Wagner, Catonsville-28-Maryland</b>				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia following La Grippe</b> Conditions, if any, which gave rise to immediate cause (b) <b>Hypertensive Cardio Vascular Disease</b> (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)				INTERVAL BETWEEN ONSET AND DEATH <b>3 weeks</b> <b>3 yrs</b>			
21. I certify that (I) (this hospital) attended the deceased from <b>Nov. 12</b> to <b>Nov. 14</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>Nov. 12</b> , 19 <b>61</b> , and that death occurred at <b>8:50 A.M.</b> from the causes and on the date stated above.				22a. SIGNATURE <b>Eliot W. Johnson</b> M.D. 22b. DATE SIGNED <b>11/14/61</b>			
22c. PHYSICIAN'S NAME (Type) <b>Eliot W. Johnson</b>				22d. ADDRESS <b>3432 Frederick Ave Baltimore 29, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11-17--1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Edward M. Haffner - Catonsville - Md.</b>				25a. REC'D BY REGISTRAR <b>NOV 16 '61</b> 25b. REGISTRAR'S SIGNATURE <b>William S. Kline</b>			

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. **12104**

12417

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>—</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Upperco</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore City</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Benson Mill Rd.</b>		d. STREET ADDRESS <b>635 S. Belnord Ave.</b>	
3. NAME OF DECEASED (Type or print) First <b>MILTON J.</b> Middle <b>WALSTON</b> Last <b>—</b>		4. DATE OF DEATH Month <b>November</b> Day <b>24</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 16, 1877</b>
9. AGE (In years lost birthday) <b>84</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>—</b> Days <b>—</b> Hours <b>—</b> Min. <b>—</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Thomas Walston</b>		14. MOTHER'S MAIDEN NAME <b>Sally Carver</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>—</b>	
17. INFORMANT <b>Harry E. Walston, 1202 Culvert Rd., Towson 4</b>		18. ADDRESS <b>—</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMATOSIS (PROSTATIC)</b> DUE TO <b>1777X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>—</b> DUE TO <b>—</b> (c) <b>—</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 MONTHS (?)</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>ARTERIOSCLEROTIC HEART DISEASE</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>—</b> p. m. <b>—</b> 19 <b>—</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>FEBRUARY 1960</b> to <b>NOVEMBER 1961</b> , that I last saw the deceased alive on <b>NOV. 19</b> , 19 <b>61</b> , and that death occurred at <b>4:30 A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>819 Park Ave. Baltimore 1, Md.</b> DATE SIGNED <b>10/24/61</b>			
ACTUAL SIGNATURE <b>Carlton L. Sexton</b>		M.D. <b>819 Park Ave. Baltimore 1, Md.</b>	
PHYSICIAN'S NAME (Type) <b>Carlton L. Sexton, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	22b. DATE THEREOF <b>11-27-61</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Fairmount Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Princess Anne, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ullrich Funeral Home, Baltimore, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>NOV 27 '61</b>	
		24b. REGISTRAR'S SIGNATURE <b>Carlton L. Sexton</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 3 & 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12418

## CERTIFICATE OF DEATH

12405

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Dundalk</i>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Dundalk</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>3404 Sollers Point Rd.</i>		d. STREET ADDRESS <i>3404 Sollers Point Rd.</i>	
3. NAME OF DECEASED (Type or print) First <i>Roland</i> Middle <i>Stanley</i> Last <i>Walter</i>		4. DATE OF DEATH Month <i>11</i> Day <i>29</i> Year <i>1961</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6-13-1924</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life; even if retired) <i>Locomotive Eng.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Railroad</i>	9. AGE (In years last birthday) <i>37</i> yrs.
11. BIRTHPLACE (County & State, or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Martin L. Walter</i>		14. MOTHER'S M maiden NAME <i>Sadie E. Henderson</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <i>yes WW 2</i>		16. SOCIAL SECURITY NO. <i>216161428</i>	
17. INFORMANT <i>Henry L. Walter</i>		Address <i>same</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Heart Disease</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <i>4 weeks</i>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		23b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <i>Oct. 1, 1952</i> to <i>Nov. 29, 1961</i> , that (I) ( <del>we</del> ) last saw the deceased alive on <i>29 Nov 1961</i> and that death occurred at <i>12:30 P.</i> from the causes and on the date stated above.			
22a. SIGNATURE <i>W.H. Morrison</i>		22b. DATE SIGNED <i>30 Nov 61</i>	
22c. PHYSICIAN'S NAME (Type) <i>W.H. Morrison</i>		22d. ADDRESS <i>3 Kinship Rd Dundalk, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>		23b. DATE THEREOF <i>12-4-61</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Baltimore National</i>		23d. LOCATION (City, town or county) (State) <i>Baltimore, Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i>		25a. REC'D BY REGISTRAR DATE <i>DEC 4 '61</i>	
ADDRESS <i>5305 Harford Rd.</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>	

VR A15 (4)  
15M 9/60

15418

15418



12-1-01  
12-1-01  
12-1-01

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

1  
FOR STATE  
HEALTH DEPT.

12419  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
124196  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>ESSEX</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>ESSEX - ZONE 21</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>HOME</u>		d. STREET ADDRESS <u>1817 WOODROW AVE.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>ANDREW</u> <u>WARSELL</u>		4. DATE OF DEATH Month Day Year <u>NOV.</u> <u>29</u> <u>1961</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC. 8 - 1885</u>
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months Days <u>11</u> <u>29</u>	IF UNDER 24 HRS. Hours Min. <u></u> <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>	
11. BIRTHPLACE (State or foreign country) <u>MINNESOTA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u></u>		16. SOCIAL SECURITY NO. <u>213-05-7843</u>	
17. INFORMANT <u>Mrs. June Warsell</u>		Address <u>above</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) (County) (State) <u></u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Joelle Collins</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JACK C COLLINS</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) <u></u>	
DATE SIGNED <u>11-29-61</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec. 2 - 61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn</u>		22d. LOCATION (City, town, or country) (State) <u>Eastern Blvd. Md.</u>	
23. FUNERAL DIRECTOR <u>John G. Connolly</u>		ADDRESS <u>Essex - 21</u>	
24a. REC'D BY REGISTRAR <u></u>		24b. REGISTRAR'S SIGNATURE <u>Arthur J. Huns</u>	
DATE <u>DEC 1 '61</u>			

RECEIVED  
FBI BUREAU

(M)

(1)

15113

15113

15113 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

IN THE DISTRICT OF COLUMBIA

DEPARTMENT OF HEALTH

OFFICE OF THE MEDICAL EXAMINER

CERTIFICATE OF DEATH

IN THE DISTRICT OF COLUMBIA

DEPARTMENT OF HEALTH

OFFICE OF THE MEDICAL EXAMINER

CERTIFICATE OF DEATH

IN THE DISTRICT OF COLUMBIA

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IN THE DISTRICT OF COLUMBIA

DEPARTMENT OF HEALTH

OFFICE OF THE MEDICAL EXAMINER

CERTIFICATE OF DEATH

IN THE DISTRICT OF COLUMBIA

DEPARTMENT OF HEALTH

OFFICE OF THE MEDICAL EXAMINER

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12420

## CERTIFICATE OF DEATH

Item 21 Film G302 12/13/61 iwk

12407

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>5 Days</b>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Baltimore</b>	
3. NAME OF DECEASED (Type or print) <b>GEORGE H. WARVEL</b>		4. DATE OF DEATH Month <b>November</b> Day <b>21</b> Year <b>1961</b>		5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Rural Mail Carrier</b>		9. AGE (In years last birthday) <b>66 yrs.</b>		10. BIRTHPLACE (County & State, or foreign country) <b>Darke, Ohio</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Darke, Ohio</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>William A. Warvel</b>		14. MOTHER'S MAIDEN NAME <b>Rhoda E. Winters</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW 1 578-07-6673</b>		17. INFORMANT <b>Clinical Records, VAH, Baltimore 18, Maryland</b> <b>FORT HOWARD DIVISION</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1 RECENT AND OLD POSTOLATERAL MYOCARDIAL INFARCTIONS</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>LEFT CORONARY THROMBOSIS</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>RECENT</b>		19. WAS AUTOPSY PERFORMED? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
21. I certify that (this hospital) attended the deceased from <b>November 16, 1961</b> to <b>November 16, 1961</b> , that (we) last saw the deceased alive on <b>November 21, 1961</b> , and that death occurred at <b>10:10 A.M.</b> from the causes and on the date stated above.		22a. SIGNATURE <b>Sebastian Russo M.D.</b>		22b. DATE SIGNED <b>11/21/61</b>		22c. PHYSICIAN'S NAME (Type) <b>SEBASTIAN RUSSO, M.D.</b>		22d. ADDRESS <b>VAH, BALTIMORE 18, MD., FT. HOWARD DIVISION</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE THEREOF <b>11-24-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Greenmount Crematory</b>		23d. LOCATION (City, town or county) (State) <b>Greenmount Ave., Baltimore, Md.</b>		24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook-Blight, Inc., 6009 Harford Road, Balto. 14, Md.</b>	
25a. REC'D BY REGISTRAR <b>NOV 27 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>		25c. REGISTRAR'S SIGNATURE		25d. REGISTRAR'S SIGNATURE		25e. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be signed by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

(M)

(1)

1943

1943

REPORT OF THE  
VETERANS ADMINISTRATION  
RESEARCH  
ON  
MAY 10, 1943  
U. S. A.  
CLINICAL RECORDS, VETERANS  
HOSPITAL DIVISION  
HOSPITAL AND OUTPATIENT  
RECORDS

NOVEMBER 10, 1943  
HOSPITAL AND OUTPATIENT  
RECORDS  
HOSPITAL DIVISION  
VETERANS ADMINISTRATION  
RESEARCH  
ON  
MAY 10, 1943  
U. S. A.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

Item 23b, Film G302 12/4/61 iwk 12408

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>30 Days</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Baltimore 1</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>788 West Mulberry Street</b>		d. STREET ADDRESS <b>788 West Mulberry Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <b>JAMES N. WASHINGTON</b>		4. DATE OF DEATH Month <b>November</b>		Day <b>24</b>		Year <b>1961</b>		5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 2, 1895</b>		9. AGE (In years last birthday) <b>66</b> yrs.		IF UNDER 1 YEAR Months <b>66</b>		IF UNDER 24 HRS. Days <b>66</b>		Hours <b>66</b>		Min. <b>66</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Laundry</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>John Washington</b>		14. MOTHER'S MAIDEN NAME <b>Hannah Goodman</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>212-01-4909</b>		17. INFORMANT <b>Clinical Records, VAH, Baltimore 18, Maryland</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CONGESTIVE HEART FAILURE</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b> DUE TO (c) <b>HEMORRHAGE, PROSTATE DUE TO CHRONIC PROSTATITIS</b>		INTERVAL BETWEEN ONSET AND DEATH <b>RECENT</b> <b>UNKNOWN</b>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>October 25, 1961, to November 24, 1961</b>		20g. (County) <b>4:30A</b>		20h. (State) <b>that (X) (we) last saw the deceased alive on Nov. 24, 1961, and that death occurred at A.M., from the causes and on the date stated above.</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
22a. SIGNATURE <b>Thomas F. Crahan</b>		22b. DATE <b>11/24/61</b>		22c. PHYSICIAN'S NAME (Type) <b>THOMAS F. CRAHAN, M.D.</b>		22d. ADDRESS <b>VAH, BALTIMORE 18, MD., FT. HOWARD DIVISION</b>		22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22f. DATE SIGNED <b>11/24/61</b>		22g. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cem.</b>		22h. LOCATION (City, town or county) <b>Baltimore 28, Maryland</b>		22i. (State) <b>Maryland</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/27/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cem.</b>		23d. LOCATION (City, town or county) <b>Baltimore 28, Maryland</b>		23e. (State) <b>Maryland</b>		23f. REC'D BY REGISTRAR <b>NOV 27 '61</b>		23g. REGISTRAR'S SIGNATURE <b>Arthur S. Travis</b>		23h. DATE <b>NOV 27 '61</b>		23i. (State) <b>Maryland</b>									
24. FUNERAL DIRECTOR'S SIGNATURE <b>Jackson Funeral Home, Inc., 916 Penna. Av., Balto.</b>		24a. ADDRESS <b>Jackson Funeral Home, Inc., 916 Penna. Av., Balto.</b>		24b. DATE <b>NOV 27 '61</b>		24c. (State) <b>Maryland</b>		24d. (State) <b>Maryland</b>		24e. (State) <b>Maryland</b>		24f. (State) <b>Maryland</b>		24g. (State) <b>Maryland</b>		24h. (State) <b>Maryland</b>									

VR A15 (4)  
15M 9/60



1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12422

CERTIFICATE OF DEATH

12409

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b> c. LENGTH OF STAY IN 1b. <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>123 Willow Ave. Towson, 4, Md.</b>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b> d. STREET ADDRESS <b>123 Willow Ave. Towson, 4, Md</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>CHARLES F WEAVER</b>		4. DATE OF DEATH Month Day Year <b>Nov. 18 19 61</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/18/83</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>	9. AGE (In years last birthday) <b>78 yrs.</b> IF UNDER 1 YEAR: Months Days Hours Min.
11. BIRTHPLACE (County & State, or foreign country) <b>Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Michael Weaver</b>		14. MOTHER'S MAIDEN NAME <b>Mary E. French</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>361-05-5224</b>	
17. INFORMANT <b>Mrs. Louise B. Hawk</b>		Address <b>123 Willow Ave. 4</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary Occlusion</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized Arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b> <b>10 yrs</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>OCT 1959</b> to <b>Nov 18, 1961</b> , that (I) (we) last saw the deceased alive on <b>Nov 16, 1961</b> , and that death occurred at <b>2 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Charles F. O'Donnell</b> M.D.		22b. DATE SIGNED <b>11/20/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>CHARLES F. O'DONNELL, M.D.</b>		22d. ADDRESS <b>7501 YORK ROAD</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Nov. 22/61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Price Cemetery</b>	23d. LOCATION (City, town or county) (State) <b>Waynesboro, Pa.</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook-Towson, Inc.</b>		25a. REC'D BY REGISTRAR <b>NOV 21 '61</b>	
ADDRESS <b>1050 York Rd. 4</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

12

5252

## Ends:

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

124110

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rosemont</b>		c. LENGTH OF STAY IN 1b <b>1</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rosemont</b>		d. STREET ADDRESS <b>2807 Louisiana Ave.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>2807 Louisiana Ave.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Martha Helen Weinelt</b>		4. DATE OF DEATH <b>Nov. 28, 19 61</b>		5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		B. DATE OF BIRTH <b>May 12, 1908</b>		9. AGE (In years last birthday) <b>53</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>Gustav Meyn</b>				14. MOTHER'S MAIDEN NAME <b>Anna Hanf</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mr. Henry J. Weinelt</b>		Address <b>Same</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized Abdominal Carcinomatosis</b> <b>199X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <b>Primary site undetermined</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>5 mos</b>						INTERVAL BETWEEN ONSET AND DEATH <b>5 mos</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>November 13, 1960</b> to <b>November 28, 1961</b> , that (I) (we) last saw the deceased alive on <b>November 27, 1961</b> , and that death occurred at <b>11:30 P.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>C. Arthur Rossberg M.D.</b>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>Nov. 29, 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>C. Arthur Rossberg</b>				22d. ADDRESS <b>2436 Washington Blvd.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Dec. 1, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Ritchie Hwy. A. A. Co., Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>George J. Gonce</b>				ADDRESS <b>4001 Ritchie Hwy. (25)</b>		25a. REC'D BY REGISTRAR <b>DATE DEC 4 '61</b>	
				25b. REGISTRAR'S SIGNATURE <b>Charles E. Hume</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1, 2, 3, and 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/60

12110

12123



RECEIVED  
JAN 10 1961  
FEDERAL BUREAU OF INVESTIGATION  
U.S. DEPARTMENT OF JUSTICE  
WASHINGTON, D.C. 20535  
TO : DIRECTOR, FBI  
FROM : SAC, NEW YORK (100-100000)  
SUBJECT: [Illegible]  
[Illegible text follows, mostly mirrored bleed-through from the reverse side of the page]

100-100000  
JAN 10 1961  
FBI NEW YORK  
[Illegible text]



Carlton & Kean

VR A15 (4)  
15M 9/60

11111

11111



11/18/61 Boston Harbor

U.S. Navy, Boston

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

12425  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

12412

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Reisterstown</u>		c. LENGTH OF STAY IN 1b <u>5 months</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		3v01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Beaumont Nursing Home</u>		e. STREET ADDRESS <u>Carey and Lanvale Hts</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>SARAH</u> Middle <u>WILMORE</u> Last <u>WILMORE</u>		4. DATE OF DEATH Month <u>November</u> Day <u>5</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/25/1875</u>
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.A.C.</u>	
13. FATHER'S NAME <u>unknown</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs Bertha Becker</u> Address <u>726 N. Carey St MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure - Chronic</u> DUE TO <u>Arteriosclerosis - generalized</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>450.05</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>Months</u> <u>Years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July 30</u> 19 <u>61</u> to <u>November 5</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>November 4</u> 19 <u>61</u> , and that death occurred at <u>4:15 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Clarence E. McWilliams</u>		22b. DATE SIGNED <u>November 5, 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>CLARENCE E. McWILLIAMS</u>		22d. ADDRESS <u>11904 Reisterstown Rd Reisterstown Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>Nov. 8, 1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>MT Auburn Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Henry James Schmitt Covings Mktg. Inc.</u>		25a. REC'D BY REGISTRAR <u>DATE NOV 7 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If 24 hours after death, it may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

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I

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
12426						12413					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)					
a. COUNTY			b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			a. STATE			b. COUNTY		
Baltimore			Timonium			Maryland			Baltimore		
c. LENGTH OF STAY IN 1b						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)					
4 Aylesbury Road						Timonium					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						d. STREET ADDRESS					
4 Aylesbury Road						4 Aylesbury Road #4					
3. NAME OF DECEASED (Type or print)						4. DATE OF DEATH					
Alice M. Young						November 13 19 61					
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		B. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR	
Female		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		2-28-1884		77 yrs.		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)						10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country)		
Retired School Teacher									Baltimore, Maryland		
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME			12. CITIZEN OF WHAT COUNTRY?		
Francis M. Young						Emma ?			U. S. A.		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)						16. SOCIAL SECURITY NO.			17. INFORMANT Address		
No									Mr. Frank E. Pennock-4 Aylesbury Road		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 334X Acute pulmonary edema											
DUE TO (b) marked cerebral, generalized arteriosclerosis											
(c) Hypertension											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year						20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
Hour a.m. p.m. 19						While et work <input type="checkbox"/> Not While et work <input type="checkbox"/>					
21. I certify that (I) (this hospital) attended the deceased from 1940 to 1961, that (I) (we) last saw the deceased alive on Nov 3 1961, and that death occurred at 7 A.M. from the causes and on the date stated above.											
22a. SIGNATURE						22b. DATE		22c. PHYSICIAN'S NAME (Type)			
Louis P. Hamburger Jr.						M.D.		Louis P. Hamburger Jr.			
22d. ADDRESS						22e. ADDRESS					
1001 St Paul St. Baltimore 2, Md.											
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)			
Cremation				11-15-61		Green Mount Crematory		Baltimore, Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Wm. J. Tucker Jr. Baltimore, Md.						DATE NOV 14 '61		C. S. Thomas			

4 3 2 1

8254



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 12114

12427

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Eastpoint</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Eastpoint</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>7440 Berkshire Rd.</b>		d. STREET ADDRESS <b>7440 Berkshire Rd.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Audrey M Young</b>		4. DATE OF DEATH <b>November 9 1961</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 20, 1923</b>
9. AGE (In years last birthday) <b>38 yrs.</b>		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At home</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Charles Milchling</b>		14. MOTHER'S MAIDEN NAME <b>Ada Davis</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>INFORMANT</b> Address <b>Roy Young 7440 Berkshire Rd.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic carcinoma</b> 199X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Pelvic Carcinoma</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>8 months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July</b> , 19 <b>61</b> , to <b>Nov</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>11-7-</b> 19 <b>61</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>B. W. Socolod</b>		ADDRESS (Street, city or town, state) <b>2902 Davis Rd. Dundalk Md</b> DATE SIGNED <b>11-11-61</b>	
PHYSICIAN'S NAME (Type) <b>B. W. Socolod</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 13, 1961</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Balto. National Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ullrich Funeral Home</b>		ADDRESS <b>Baltimore, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>NOV 14 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kimes</b>	

CERTIFICATE OF DEATH

1912



Baltimore

Indisposed

Wm. H. Karpis Jr.

Arrested

At home

Charles H. Helling

John Davis

28

March 10, 1935

Westland

1935

John Davis, 2100 Parkview St.

*John Davis*

John Davis

*John Davis*

John Davis, 2100 Parkview St., Baltimore, Md.  
Baltimore, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
12428											
CERTIFICATE OF DEATH											
Item 1c Film G302 12/4/61 iwk 12415											
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore Catonsville</u> c. LENGTH OF STAY IN TB <u>35 years</u> <u>14 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Spring Grove State Hospital</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>4126 Norfolk Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last <u>Rudolph</u> <u>Zinober</u>						4. DATE OF DEATH Month Day Year <u>November</u> <u>26</u> <u>19 61</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>October</u> <u>1894</u>		9. AGE (In years last birthday) yrs. <u>67</u>		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tailor</u>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13. FATHER'S NAME <u>unknown Joshua</u>						14. MOTHER'S MAIDEN NAME <u>unknown Berne</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>unknown</u>				16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT <u>Albert Zinober</u>		Address <u>3400 Oakfield Ave. Baltimore</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema and congestive heart failure</u> 422 } DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Infarctive myocardial fibrosis</u> (a), stating the underlying cause last. } DUE TO (c) <u>Arteriosclerotic cardiovascular disease</u>										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>Nov. 12</u> <u>7:35</u> to <u>Nov. 26</u> , 19 <u>61</u> that (I) (we) last saw the deceased alive on <u>Nov. 26</u> <u>1961</u> , and that death occurred at <u>p.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>Stella Wachslar</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>11-27-61</u>			
22c. PHYSICIAN'S NAME (Type) <u>Stella Wachslar, M. D.</u>						22d. ADDRESS <u>SPRING GROVE STATE HOSPITAL</u> <u>Catonsville 28, Maryland</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>11/28/1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt Carmel</u>				23d. LOCATION (City, town or county) (State) <u>Balto. Md.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Lewis</u>						25a. REC'D BY REGISTRAR <u>NOV 29 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur J. Hines</u>			

13434

13434

(M)

(1)

*[Signature]*

*[Signature]*

*[Signature]*

13434

13434

*[Signature]*

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12429

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. LENGTH OF STAY IN 1b <u>4yr9mth</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Alice</u> Middle <u>Almira</u> Last <u>Zittle</u>				4. DATE OF DEATH Month <u>November</u> Day <u>28</u> Year <u>1961</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 9, 1885</u>	
9. AGE (In years last birthday) <u>76</u> yrs.		10. IF UNDER 1 YEAR Months <u>76</u> Days <u>76</u> Hours <u>76</u> Min. <u>76</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>			
13. FATHER'S NAME <u>James R. Stran</u>				14. MOTHER'S MAIDEN NAME <u>Sabina Prince</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u>				16. SOCIAL SECURITY NO. <u>unknown</u>			
17. INFORMANT <u>Records: a SPRING GROVE STATE HOSPITAL</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute congestive heart failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>Arteriosclerotic heart disease due to generalized arteriosclerosis.</u> DUE TO (c) <u>arteriosclerosis.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Obesity</u>							
INTERVAL BETWEEN ONSET AND DEATH							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Feb. 28</u> <u>1:50</u> to <u>Nov. 28</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>Nov. 28</u> 19 <u>61</u> , and that death occurred at <u>1:50</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Stella Wachslor</u>				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>STELLA Wachslor</u>				22d. ADDRESS <u>SPRING GROVE STATE HOSPITAL</u> <u>Catonsville 28, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>12/2/61</u>				23b. DATE THEREOF			
23c. NAME OF CEMETERY OR CREMATORY <u>GLLEN HAVEN</u>				23d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>1305 Fort Ave.</u>				25a. REC'D BY REGISTRAR DATE <u>DEC 1 '61</u>			
				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

STATE OF TEXAS

15452

15452

(M)

(1)

MADE IN U.S.A.